

**MEDI-CAL
NOVEMBER 2012
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2012-13 and 2013-14**

ASSUMPTIONS

Fiscal Forecasting and Data Management Branch
State Department of Health Care Services
1501 Capitol Avenue, Suite 6069
Sacramento, CA 95814
(916) 552-8550



EDMUND G. BROWN JR.
Governor
State of California

Diana Dooley
Secretary
California Health and Human Services Agency

Toby Douglas
Director
Department of Health Care Services

MEDI-CAL ASSUMPTIONS
November 2012
FISCAL YEARS 2012-13 & 2013-14

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INTRODUCTION

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction, and is derived from a 36-

month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Estimate.

Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.

FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and \$/claim or \$/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

	USERS	=	f(TND, S.DUM, O.DUM, Eligibles)
	CLAIMS/USER	=	f(TND, S.DUM, O.DUM)
	\$/CLAIM	=	f(TND, S.DUM, O.DUM)
WHERE:	USERS	=	Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	=	Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\$/CLAIM	=	Total monthly \$ divided by total monthly claims or units by service and aid category.
	TND	=	Linear trend variable.
	S.DUM	=	Seasonally adjusting dummy variable.
	O.DUM	=	Other dummy variables (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.).
	Eligibles	=	Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and \$/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

ELIGIBILITY: NEW ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 0.1	(PC-9) (CA-8)	X	X	<p><u><i>Maternal and Child Health Access (MCHA) vs. DHCS and MRMIB</i></u></p> <p>The Department uses the Single Point of Entry (SPE) to process joint applications that serve as an application for the Healthy Families Program (HFP) and a screening device for the Federal Poverty Level (FPL) Medi-Cal program. MCHA contends that the Department and Managed Risk Medical Insurance Board (MRMIB) are required to use the joint application as an application for all Medi-Cal programs, not just the FPL program, as is the current practice. In addition, MCHA raised several other issues relating to the administration of SPE, including notice requirements and infant eligibility.</p> <p>On December 6, 2010, the court issued its decision ruling in favor of the Department on all issues except that for children ages 6-18 the State must screen for section 1931(b) Medi-Cal before enrolling the child in HFP. Most significantly, the court upheld the Department's current practice of using the joint application as a screen for only one Medi-Cal program and the ruling did not change the current screening for the FPL Medi-Cal program.</p> <p>On July 10, 2012, San Francisco Superior Court issued an order enforcing writ requiring that, by August 31, 2012, the SPE conduct the 1931(b) Medi-Cal program screen using the current application for children age 6 up to age 19 before enrolling a child in the HFP. The Department previously had agreed to implement a screen at SPE to identify "deemed eligible" infants. The court ordered that Department and MRMIB file a status report by September 4, 2012. These requirements will result in an increase in caseload duties for county eligibility workers and additional benefit costs. No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and all applications submitted to SPE will be sent to county eligibility workers for a Medi-Cal determination.</p>

"PC" refers to "Policy Change".

"PC-1" means the fiscal impact of this assumption is in Policy Change 1.

"PC-BA" indicates the fiscal impact is a base adjustment or other part of the base.

"PC-CA" means there is a fiscal impact on County Administration.

"PC-OA" means there is a fiscal impact on Other Administration.

"PC-NA" means there is no fiscal impact or that the fiscal impact is unknown.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
E 1	(OA-13) (OA-63) <u>(OA-73)</u>	X	X	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which is also used as a screening tool for the Medi-Cal children's percent programs. This form is sent to a Single Point of Entry (SPE), where it is screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination for the children's percent programs or to MRMIB for a Healthy Families determination.</p> <p>The Department pays the federal Title XIX and the federal Title XXI share for the Medi-Cal applications through an interagency agreement with MRMIB. <u>The Department will continue to pay the federal share for the Medi-Cal applications; however, the interagency agreement with MRMIB will be eliminated in early 2013 upon final execution of a DHCS contract with MAXIMUS. No sooner than January 1, 2013, when MRMIB ceases to enroll new applicants, all applications submitted to SPE, whether paper or electronic, will be screened and forwarded to counties for a Medi-Cal determination.</u></p> <p>Effective October 1, 2012, the HFP will cease to enroll new applicants and will be phased out over a nine-month period. Children enrolled in the HFP will be transitioned to the Medi-Cal Program as targeted low-income children.</p>
E 2	(PC-2) (PC-6)	X	X	<p><u>Bridge to HFP</u></p> <p>The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi-Cal or are eligible for Medi-Cal with a SOC. To be eligible for this Bridge, a child must have income at or below the Healthy Families income standard of 250% <u>200%</u> of poverty (although the use of an income disregard effectively raises the upper limit to more than 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the one month of additional eligibility. Plans receive an additional capitation payment for each of these member months.</p> <p>Effective October 1, 2012 <u>No sooner than January 1, 2013</u>, the HFP will cease to enroll new applicants <u>subscribers</u> and will be phased out over a nine-month period <u>HFP subscribers will transition into Medi-Cal through a phase-in methodology</u>, which will eliminate the need for the bridge from Medi-Cal to the HFP.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 3	(PC-15)	X	X	<u>Resource Disregard – % Program Children</u> Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children's Health Insurance Program (SCHIP).
E 4	(PC-14)	X	X	<u>New Qualified Aliens</u> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Aliens who enter the country on or after August 22, 1996, for the first five years they are in the country. Most New Qualified Aliens are only eligible for FFP for emergency services and pregnancy-related services. California is continuing to provide full-scope Medi-Cal services to aliens who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Aliens is being identified through a retroactive tracking system and the federal government is being reimbursed on a retroactive basis for the FFP paid that is not available for these services. PRWORA requires deeming an alien's sponsor's income and resources for Medicaid. <u>The Department is awaiting guidance from CMS to determine if FFP is available for services provided to Newly Qualified Aliens who have been in the country for five years and after the federal sponsored alien rules are applied.</u> Once a New Qualified Alien has been in the country for five years and the federal sponsored alien rules are applied, FFP is available for all services. The Centers for Medicare & Medicaid Services (CMS) has not issued instructions on how the sponsored alien rules are to be implemented by the states. The Department will continue to claim FFP for nonemergency services for sponsored persons who have been here for more than five years until those instructions are issued.
E 5	(PC-7)	X	X	<u>Refugees</u> The federal Refugee Act of 1980 provides states with 100% of a State's Medicaid cost of services to Refugee Cash Assistance and Refugee Medical Assistance programs for up to eight months from the date of arrival in the United States, date of final grant of asylum, and date of certification for trafficking victims. <u>The California Department of Public Health (CDPH) administers</u> California's Refugee Resettlement Program federal grant is administered by the California Department of Public Health (CDPH) and the

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

				Department invoices CDPH for the reimbursement of the Medical Assistance Program expenditures.
E 6	(OA-24)	X	X	<p><u>SSA Costs for Health Coverage Information</u></p> <p>The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.</p>
E 7	(OA-8)	X	X	<p><u>Postage & Printing</u></p> <p>Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and the mailing to beneficiaries or distribution to community based organizations and counties are performed by the Health Care Options vendor. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP are included in this item.</p> <p>Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.</p>
E 8	(CA-10)	X	X	<p><u>Systematic Alien Verification Entitlement System</u></p> <p>The federally mandated Systematic Alien Verification Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing Income and Eligibility Verification System to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
E 9	(OA-55)	X	X	<u>Maternal and Child Health-CDPH</u> Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women, infants, children, and adolescents: (1) reduction of high death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies. Effective July 1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.
E 10	(OA-62)	X	X	<u>Outreach – Children</u> The Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997) established funding for children's outreach. Activities included media, public relations, collateral, certified application assistance, and a toll-free line. In the Budget Act of 2003, outreach was limited to funding of a toll-free line. An interagency agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004. Effective October 1, 2012 <u>No sooner than January 1, 2013</u> , the HFP will cease to enroll new applicants <u>subscribers</u> and will be phased out over a nine-month period <u>HFP subscribers will transition into Medi-Cal through a phase-in methodology.</u> The Department will continue to fund the toll-free line, but the interagency agreement with MRMIB will be eliminated <u>terminated upon execution of a new contract for those services between the Department and Maximus.</u>
E 11	(CA-2)	X	X	<u>Statewide Automated Welfare</u> The Statewide Automated Welfare Systems (SAWS) consist of three county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV) and the CalWORKs Information Network (CalWIN). The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces. The LEADER is the automated system for Los Angeles County and it is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has completed contract

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

negotiations with the successful bidder (Accenture). ~~OSI and the County have submitted~~ **Federal oversight agencies have reviewed and approved** the LEADER Replacement System (LRS) development contract, **currently scheduled for initiation in September 2012.** ~~to the federal oversight agencies for their review and approval. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract for an additional two years, through April 2013, with up to two optional one-year extensions beyond that date. The two one-year extensions are subject to state and federal approvals~~ **2015.**

~~The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase.~~

~~The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.~~

The CalWIN consortium and C-IV system are in the maintenance and operation phase.

The State and the counties in the current LEADER and C-IV consortia are working together to develop a new consortium.

E 12 (CA-3) X X CalWORKs Applications

Beginning in 1998 a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.

E 13 (PC-4) X X CHDP Gateway
 (PC-FI)

In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, children receiving a CHDP screen are pre-enrolled in Medi-Cal/Healthy Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal/Healthy Families coverage. To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a CHDP cover letter and Healthy Families application form that is also used to screen for the Medi-Cal children's percent programs. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in ~~twelve~~ **Medi-Cal threshold** languages. The Healthy Families application is returned to the Single Point of Entry (SPE) and is screened for the Medi-Cal children's percent programs and forwarded to the county for a Medi-Cal determination or to Healthy Families.

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Funding ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.

Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.

Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.

~~Effective October 1, 2012~~ **No sooner than January 1, 2013**, the HFP will cease to enroll new applicants **subscribers** and ~~will be phased out over a nine-month period~~ **HFP subscribers will transition into Medi-Cal through a phase-in methodology**. Children enrolled **subscribed** in the HFP will be transitioned to the Medi-Cal Program, and children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal. **DHCS will continue to receive enhanced Title XXI funding for these children.**

E 14 (OA-72) X X Merit System Services for Counties

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi-Cal staff in 30 County Welfare Departments (CWD) and oversight in the other 28 counties.

E 15 ~~(CA-5)~~ X X County Cost of Doing Business
 ~~(CA-6)~~
 (CA-9)

Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations are limited to a maximum increase of the California Necessities Index (CNI) as calculated by the Department of Finance, or state employee salary increases, whichever is greater. ~~The FY 2011-12 and FY 2012-13 increases are 1.92% and 2.98%, respectively.~~

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

E 16	(CA-5)	X	X	<p><u>Los Angeles County Hospital Intakes</u></p> <p>Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for Medi-Cal applications taken in Los Angeles County hospitals. Welfare & Institutions (W&I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.</p>
E 17	(CA-4)	X		<p><u>Eligible Growth</u></p> <p>The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases.</p>
E 18	(OA-58)	X	X	<p><u>Department of Social Services Administrative Costs</u></p> <p>The Department provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), via interagency agreements (IAs), for the administrative costs related to services provided to Medi-Cal beneficiaries under the In-Home Supportive Services Personal Care Services Program (IHSS PCSP), the Child Welfare Services/Case Management System (CWS/CMS), and the Statewide Automated Welfare System (SAWS), and the Independence Plus Option Section 1915 (j) (IPO) waiver.</p>
E 19	(OA-NA)			<p><u>Health-e App</u></p> <p>This assumption has been moved to "Time Limited/No Longer Applicable" section.</p>
E 20	(PC-18)	X	X	<p><u>PARIS-Interstate and PARIS-Federal</u></p> <p>The Public Assistance Reporting Information System (PARIS) matches allow Interstate match allows states to compare beneficiary information with the U.S. Department of Defense, the U.S. Office of Personnel Management and other states to identify federal pension income or health benefits as well as changes in residence and public assistance benefits in other states.</p>

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

E 21 (PC-16) X X PARIS-Federal

The PARIS-Federal match allows states to compare beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management to identify federal pension income or health benefits provided by the federal government.

E 22 (CA-13) X X County Administration Reconciliation

Within two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. In FY 2012-13, the Department will complete the reconciliation for FY 2010-11 and FY 2011-12. **In FY 2013-14, the Department will complete an interim reconciliation for FY 2012-13.**

E 23 (CA-NA) X X Low-Income Subsidy Applications Treated as Medi-Cal Applications

This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.

E 24 (OA-47) X X Q5i Automated Data System Acquisition

The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance and support. The Q5i system is used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control, County Performance Standards, Payment Error Rate Measurement, and Anti-Fraud/Program Integrity.

E 25 (OA-16) X X Medi-Cal Eligibility Data System (MEDS)

MEDS is currently the only statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status.

Funding is required for MEDS master Client Index maintenance, data matches from various federal and state agencies, SSI termination process support, Medi-Cal application alerts, MMA Part D buy-in process improvements, eligibility renewal process, and reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities. Costs currently are offset by reimbursements made from other state departments using MEDS.

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

In addition, maintenance funding is required for the Business Objects (BO) software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.

E 26 (OA-60) X X Veterans Benefits

AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.

E 27 (PC-13) X X CHIPRA – Elimination of 5-Year Bar on Full-Scope Medi-Cal for Children and Pregnant Women

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the U.S. for less than five years and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children under the age of 21 or pregnant women even if they have been in the U.S. for less than five years. The Department ~~has received federal approval to implement~~ **and implemented** this option **effective on** April 1, 2009.

E 28 (PC-10) X X Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements beginning in FY 2011-12. **If eligible for Medi-Cal, Residents residents** moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system.

E 29 (PC-11) X X 250% Working Disabled Program (WDP) Changes

The WDP, established in April 2000, allows for employed individuals with disabilities to earn up to 250% of the federal poverty level and receive full

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

scope Medi-Cal benefits. All eligible individuals and couples are required to pay a monthly premium based on their countable income.

AB 1269 (Chapter 282, Statute of 2009) requires the Department to implement changes to the program 30 days after ARRA enhanced federal funding ends on June 30, 2011. The provisions are:

1. Exemption of disability income that converts to retirement income.
2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.
3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.
4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

However, under the Maintenance of Effort (MOE) requirements of the Affordable Care Act (ACA) 2010, states cannot implement more restrictive Medicaid eligibility policies, procedures or methodologies without the possibility of losing federal funding for their Medicaid programs. The MOE provisions are in effect until January 1, 2014 for adults and 2019 for children. Therefore, the Department will not be able to implement provision four at this time, since it would be more restrictive. The first three provisions were implemented effective August 1, 2011.

E 30	(CA-10) (CA-11) (CA-12)	X	X	<p><u>Reduction of CNI-Based COLA to Counties</u></p> <p>The Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated for FY 2011-12 2012-13 and FY 2012-13 2013-14.</p>
E 31	(PC-5) (PC-8) (OA-32)	X	X	<p><u>Medi-Cal Inpatient Services for Inmates</u></p> <p>AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department, counties, and the California Department of Corrections and Rehabilitation (CDCR) to claim federal reimbursement for inpatient hospital services for Medi-Cal eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Effective April 1, 2011, the Department began accepting Medi-Cal applications from the California Correctional Health Care Services (CCHCS) for eligibility determinations for State inmates. Claims will be processed retroactive to November 1, 2010. The Department will budget the FFP for services and CDCR administrative costs and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF. <u>Additionally, the Department is taking steps to implement Medi-Cal coverage of</u></p>

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

inpatient hospital services provided off the grounds of the correctional facility for eligible county inmates.

AB 396 (Chapter 394, Statutes of 2011) authorized the Department and counties to claim federal reimbursement for inpatient hospital services and inpatient psychiatric services for Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to grant medical parole to permanently medically incapacitated state inmates. A State inmate granted medical parole is potentially eligible for Medi-Cal. When an inmate is granted medical parole, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.

E 32 (PC-12) X X Lomeli, et al., v. Shewry

The Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. As a result, the Department sends notices to new SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and new SSI recipients, informing them of the availability of retroactive coverage.

E 33 (PC-NA) Craig v. Bontá Disallowance

This assumption has been moved to "Time Limited/No Longer Applicable" section.

E 34 (PC-17) X X PARIS-Veterans Match

The federal Public Assistance and Reporting Information System (PARIS) is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS-Veterans match allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs.

The PARIS-Veterans match allows the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification enhances the Department's potential to shift healthcare costs from the Medi-Cal program to the United States Department of Veterans Affairs (USDVA). The Department implemented a Veterans Match Pilot Program on July 1, 2009, which filters the PARIS

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

				match results and focuses outreach efforts on veteran Medi-Cal beneficiaries receiving long-term care services in three ten counties.
E 35	(PC-2) (PC-62) (PC-64) (PC-FI) (OA-13) (CA-7)	X	X	<p>Shift Transition of Healthy Families Children to Medi-Cal</p> <p>Effective October 1, 2012, AB 1494 (Chapter 28, Statutes of 2012 requires, effective January 1, 2013, that children enrolled subscribed in the HFP will be shifted to the Medi-Cal program over a nine-month phased-in period be transitioned into Medi-Cal through a phase-in methodology. Coverage of this population under Medicaid programs is permissible pursuant to the federal Social Security Act to provide full scope Medi-Cal benefits to such eligible children who are optional targeted low-income children with family incomes up to and including 200% of the federal poverty level (FPL).</p> <p>Assets will be exempt for these children and an income disregard will be applied for children with incomes between 200% and 250% of the FPL, available creating an effective income level not to exceed 200 250% of the FPL. Individuals with incomes above 150% and up to 200 250% of the FPL will be subject to premiums at the same level of the Community Provider Plan (CPP) option as used under the current HFP. Children with incomes at and below 150% of the FPL will not pay premiums.</p> <p>Consistent with the ACA, children with incomes up to 133% of the FPL will be mandatorily enrolled into Medicaid programs beginning January 1, 2014. In pursuing this option to cover these targeted low income children, the benefits and administrative costs provided to these children are eligible for enhanced federal funding of 65% under Title XXI, and the associated administrative costs are eligible for 50% federal funding under Title XIX. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service arrangements. Implementation is contingent upon enactment of State statute and receiving necessary federal approvals.</p> <p>The MRMIB, in consultation with the Department, will provide written notice to beneficiaries enrolled in Healthy Families of their transition to the Medi-Cal program and changes they should anticipate prior to their movement into Medi-Cal.</p> <p><u>Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) beneficiaries are carved out and provided by county mental health departments. Specialty mental health services for HFP SED beneficiaries transferred into the Medi-Cal program will continue to receive these services through county mental health departments. County mental health departments are eligible to claim FFP through the CPE process.</u></p>

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA will establish a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the current practice of using various income disregards to adjust family income will be replaced with a single 5% income disregard. The ACA will also simplify the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons will not change.

The new standard will allow current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

In addition, the ACA will impose a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled, in Medi-Cal to enroll in the program. The Department expects this expansion group, to the extent the State chooses to exercise this option, and the currently eligible but not enrolled population to result in a significant number of new Medi-Cal beneficiaries.

For those newly eligible adults in the expansion group, the ACA will provide California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled, in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA will increase the CHIP FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

The ACA requires the Department to establish a benefit package, called a benchmark plan, for the expansion population. CMS has not released the final rules that will govern the benchmark plan and, consequently, it is unknown what type of benchmark plan California will choose to offer.

The Department is currently assessing all required administrative changes that will be required to implement various other ACA rules as well as several provisions offered as options for states. Because various aspects of how the ACA will be implemented are still unknown, the Estimate only contains policy changes to estimate the following costs:

- Drug Medi-Cal;
- Medicaid Emergency Psychiatric Demonstration;
- Add-on for LTC (Non-AB 1629 & AB 1629) Facilities;
- Recovery Audit Contract;
- HIPPA Operating Rules.

Other impacts to Medi-Cal will be determined in future Estimates.

AFFORDABLE CARE ACT: NEW ASSUMPTIONS

	Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
ACA 0.1 (PC-138) (PC-140)	X	<u>Add-on for LTC (Non-AB 1629 & AB 1629) Facilities</u> Effective 2014, under the Affordable Care Act, long-term care facilities which elect to provide health insurance for employees, and are not currently doing so, will experience additional costs to provide health coverage. An add-on to the rates to reimburse the facilities for the additional costs will be effective 2014.
ACA 0.2 (PC-21) (OA-51)	X	<u>Recovery Audit Contractor</u> The Department has proposed legislation to enter into contracts with one or more eligible Medicaid Recovery Audit Contractors (RACs) pursuant to section 6411(a) of the ACA. RACs' duties include reviewing post payment fee-for-service Medi-Cal claims, identifying improper payments, and educating providers. RACs are paid on a contingency basis based on the following terms: <ul style="list-style-type: none"> • 12.5% of amounts recovered after an identified overpayment, and • 10% of amounts refunded after an identified underpayment. The Department does not assume any cost for the contract. The Department awarded Health Management Systems, Inc. (HMS) the contract in April 2012 and expects to approve the final contract in FY 2012-13.
ACA 0.3 (PC-FI)	X	<u>HIPAA Operating Rules</u> The ACA includes new HIPAA Operating Rules that stipulate how transactions work. The FI intends to make modifications to California Medicaid Management Information System (CA-MMIS) through a change order to meet the new requirements for these transactions by the compliance date of January 1, 2013.
ACA 0.4 (PC-19) (PC-20)	X	<u>Disproportionate Share Hospital Reduction</u> The ACA requires the aggregate, nationwide reduction of State Disproportionate Share Hospital (DSH) allotments of \$500 million for FY 2013-14. Reductions will increase for each fiscal year through FY 2019-20. The reduction for each state will be determined by CMS.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
ACA 1 (PC-136)	X	X	<u>ACA— Payments to Primary Care Physicians</u>
			The ACA requires Medi-Cal to increase primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department will receive 100% FFP for the additional incremental increase in Medi-Cal rates that were in effect as of July 1, 2009 to the Medicare level for primary care services.
ACA 2 (PC-51)	X	X	<u>Managed Care Drug Rebates</u>
			The ACA extend extended the federal drug rebate requirement to Medicaid managed care outpatient covered drugs. In addition to <u>County Organized Health Systems</u> , Medi-Cal drug rebates are now also provided by: <ul style="list-style-type: none"> • Geographic Managed Care (GMC) <u>health plans</u> • Two-Plan model <u>health</u> plans, and the • Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). <p>Previously, only COHS <u>health</u> plans except for HPSM were subject to the rebate requirement.</p> <p>The Department will invoice for these rebates, retroactive to March 23, 2010, beginning in August 2012 <u>March 2013</u>.</p>
ACA 3 (PC-41)	X		<u>Federal Drug Rebate Change</u>
			The ACA increases the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increases the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming 100% of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program because California currently collects rebates at the higher percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.
ACA 4 (OA-7)	X	X	<u>CalHEERS Development</u>
			The ACA mandates the establishment of health insurance exchanges, in California, known as the Health Benefit Exchange (HBEX) to provide competitive health care coverage for individuals and small employers. As required by ACA, States must establish a "one-stop-shop" <u>the ability</u> to accept online application and to determine an applicant's eligibility for subsidized coverage. In creating this "one-stop-shop" experience, States are also required to use a single, streamlined application to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone with an Exchange, or <u>with</u> the Medicaid and Children's Health Insurance Program (CHIP) agency. To meet this

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

requirement, the Department, ~~MRMIB~~, and the Exchange have formed a partnership to acquire a Systems Integrator to design and implement the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) as the business solution ~~that will allow the required one-stop shopping, making health insurance eligibility and purchasing easier and more understandable.~~

ACA also offers new enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required Exchanges.

ACA 5 (OA-26) X
 (OA-39)

X

MEDS Integration into CalHEERS

CalHEERS will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through ~~the~~ HBEX, Medi-Cal and the Healthy Families program. In order to provide seamless integration with the new CalHEERS system, the Department will establish and design the implementation of technology solutions for ongoing maintenance of Medi-Cal Eligibility Data System (MEDS) changes and integration with CalHEERS.

The Department will receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related systems changes needed to interface with ~~the~~ CalHEERS.

The Department will hire a contractor to conduct a feasibility study and develop a federal Advanced Planning Document (APD) for transitioning MEDS from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the ACA, and increases the Department's alignment with the federal Medicaid Information Technology Architecture (MITA).

ACA 6 (OA-21) X

X

Prevention of Chronic Disease Grant Project

Section 4108 of the ACA authorizes the five-year Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project. The Department was awarded 100% federal funds to implement ~~Increasing Quitting among Medi-Cal Smokers project the MIPCD grant project~~ **the Medi-Cal Incentives to Quit Smoking Project**. This project will use outreach and incentives to encourage access to smoking cessation services for Medi-Cal beneficiaries. The Department ~~will enter into a contract~~ **has established an Interagency Agreement** with UCSF for the administration, implementation, and evaluation of the MIPCD project.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

ACA 7 (PC-173) X X Community First Choice Option

Section 2401 of the ACA establishes a new State Plan option to provide home and community-based attendant services and supports. These services and supports may be offered through the federal Community First Choice Option (CFCO). The CFCO, which was available **commencing** October 1, 2010, allows States to receive a 6% increase in federal match for expenditures related to this **option retroactively to December 1, 2011.**

~~CMS has not released final regulations.~~ On December 1, 2011, the Department and CDSS, submitted a SPA proposing to transition eligible participants in the Personal Care Services and In-Home Supportive Services Plus Option programs into CFCO. ~~Once approved by CMS, the additional Title XIX funds will be available under CFCO.~~ **The SPA, approved on September 4, 2012, allows additional Title XIX funds to be available under CFCO.**

On May 7, 2012, CMS released the final regulation requiring that to be eligible to receive CFC services, individuals must meet the following requirements:

- **An institutional level of care furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded,**
- **An institution providing psychiatric services for individuals under 21, or**
- **An institution for mental diseases for individuals age 65 or over.**

Since California submitted its SPA prior to the publication of the final regulation, CMS will provide the State with a transitional period of one year from the effective date of the CFC final regulation to comply with the eligibility criteria in the final regulation. This level of care criteria will sunset July 6, 2013. Thus, the Department must amend the SPA effective July 6, 2013, to reflect updates to the State Plan that are in compliance with the final regulation.

ACA 8 (PC-FI) X X Implementation of New Federal ACA Rules (Federal Register Vol. 76, No. 22)

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal dental program. The new rules establish **additional** requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

To stay in compliance, ~~the Department plans to hire additional FI staff to complete the increased workload~~ **the FI will hire additional staff.** ~~The Department plans to incur cost.~~ **Costs will be incurred** once all control

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

agencies negotiate and approve a change order in the first quarter of FY
2012-13 October 2012.

BENEFITS: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 0.1 (PC-30)	X	X	<p><u>Family PACT Retroactive Eligibility</u></p> <p>Effective April 1, 2011, Medi-Cal allows retroactive eligibility for Family PACT qualifying clients for up to three months prior to the first day of the month of application to the Family PACT program.</p> <p>The Department implemented the following:</p> <ul style="list-style-type: none"> • Retroactive eligibility certification procedure, • Claim process for newly-enrolled clients, and • Procedures to ensure reimbursement for retroactive period.
B 0.2 (PC-36)	X	X	<p><u>Cervical Cancer Screening</u></p> <p>Currently, women age 25 and older receive a Papanicolaou (Pap) test every year. If the Pap test is abnormal, additional tests may be allowed. The clinician determines the frequency of the Pap test based on the woman's risks and the need to follow-up abnormal results.</p> <p>The United States Preventive Services Task Force (USPSTF) guideline for cervical cancer screening was revised on March 2012.</p> <p>The recommendations for cervical cancer screening are the following, except for women with prior high grade precancerous lesions and those who are immunocompromised:</p> <ul style="list-style-type: none"> • Before Age 21: No Pap test • Age 21 – 29: Pap test every three years • Age 30 – 65: Pap test every three years or Pap test and HPV test every five years • After Age 65: No Pap test <p>Effective January 1, 2013, the Department will implement the new guidelines for cervical cancer screening.</p>
B 0.3 (PC-27)	X	X	<p><u>Dense Breast Notification Supplemental Screening</u></p> <p>SB 1538 (Chapter 458, Statutes of 2012) would require health facilities administering mammograms to notify patients whose breasts are categorized as being heterogeneously or extremely dense and inform the patients that they may benefit from supplementary screening due to the level of dense breast tissue (DBT) seen on the mammogram. The generated notices will result in patients requesting additional screening tests, such as magnetic resonance imaging (MRIs) and ultrasounds. The provisions of this bill will become operative April 1, 2013 and sunset on January 1, 2019.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 1	(OA-56)	X	X	<u>Public Health Nurses for Foster Care</u> <p>The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The program is administered by the Children's Medical Services Branch in DHCS, via <u>The Department has</u> an interagency agreement with CDSS.</p> <p>On October 7, 2008, P.L. 110-352, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was signed into law. P.L. 110-351 is an amendment to the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, and improve incentives for adoption. On January 1, 2010, the Department, through CDSS, implemented the new requirements to provide Health Oversight and Coordination.</p>
B 2	(PC-23)	X	X	<u>Local Education Agency (LEA) Providers</u> <p>Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. LEAs claim FFP for specific services as authorized in W&I Code Section 14132.06. LEA providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.</p>
B 3	(PC-178)	X	X	<u>Medi-Cal TCM Program</u> <p>The Targeted Case Management (TCM) program provides funding to counties and chartered cities/local government agencies (LGAs) for assisting Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. Through rates established in the annual cost reports, local governments claim FFP for these case management services. TCM providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.</p>
B 4	(PC-176)	X	X	<u>Targeted Case Management Services – CDDS</u> <p>The Department provides Title XIX FFP for regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case</p>

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.

B 5 (OA-NA) X

Disease Management Program

This assumption has been moved to "Time Limited/No Longer Applicable" section.

B 6 (OA-1) X X
(OA-9)

Medi-Cal Administrative Activities

AB 2377 (Chapter 147, Statutes of 1994) authorized the State to implement the Medi-Cal Administrative Claiming process. The Medi-Cal program submits claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.

Both LGAs and local educational "consortiums" (LECs) contract with the Department for reimbursement and may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when additional funds, such as special local initiatives and Proposition 10 fund spending determination of LGA status, are made available as the certified public expenditure.

SB 308 (Chapter 253, Statutes of 2003) redefines LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) program. CMS approved the California Tribal MAA Implementation Plan on January 9, 2009, which allows Tribal Entities and Tribal Organizations to participate in the MAA program by contracting with the State to receive reimbursement. On December 18, 2009, CMS approved reimbursement for non-emergency, non-medical transportation expenditures for Tribal entities.

The Department is currently working with CMS on an implementation plan for mental health plans to claim FFP for MAA.

B 7 (PC-33) X X

SCHIP Funding for Prenatal Care

In order to maximize revenues ~~revenues~~ **federal funding**, the Budget Act and Health Trailer Bill of 2005, require **SB 77 (Chapter 38, Statutes of 2005), requires** MRMIB to file a SPA in the CHIP to claim **Title XXI** 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100%

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

General Fund. ~~The SPA which was filed on June 30, 2005 allows SCHIP funding to be claimed for both 2004-05 and 2005-06 in 2005-06.~~ Funding is being claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. CMS approved the SPA in March 2006.

B 8 (OA-12) X X Coordinated Care Management Pilot

The Budget Act of 2006 includes approval to establish and implement a Coordinated Care Management (CCM) Demonstration Project. The key elements of the CCM Project include maintaining access to medically necessary and appropriate services, improving health outcomes, and providing care in a more cost-effective manner for two populations enrolled in the fee-for-service Medi-Cal Program who are not on Medicare:

- CCMP-SPD (CCM-1): Seniors and persons with disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; and
- CCMP-SMI (CCM-2): Persons with chronic health condition(s) and serious mental illnesses.
- CBAS (CCM-2): This contract has been amended to include Adult Day Health Care (ADHC) services as the Department transitions eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit.

APS Healthcare Inc. has been awarded both CCM-1 and CCM-2 contracts, which began in January 2010 and April 2010 respectively.

B 9 (PC-189) X X CLPP Funding for EPSDT Lead Screens

Medi-Cal receives funding from the CLPP Fund to cover Early Periodic Screening, Diagnosis and Treatment (EPSDT) blood lead testing for beneficiaries with risk factors for lead poisoning. CLPP funding will be used for the non-federal share of the cost.

B 10 (PC-NA) X X Elimination of OTC Acetaminophen Drugs

This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.

B 11 (PC-37) X X Physician and Clinic Seven Visits Soft Cap

AB 97 (Chapter 3, Statutes of 2011) caps the number of physician visits and clinic visits (including visits at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)) at seven per fiscal year per Medi-Cal beneficiary. Visits that meet one of the five exception

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

circumstances are not counted in the seven-visit cap. This cap applies to adults 21 years of age or older, except those in nursing facilities, pregnant women, presumptive eligibility and FPACT beneficiaries. The cap applies only to Medi-Cal fee-for-service (FFS); managed care plans already control utilization more tightly than the cap process.

B 12 (PC-34) X X Hearing Aid Cap

AB 97 (Chapter 3, Statutes of 2011) implements a \$1,510 cap per beneficiary for hearing aid expenditures. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not in nursing facilities or pregnant women.

B 13 (PC-39) X X Copayment for Non-Emergency ER Visits

AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions in the managed care setting. The hospital will collect the copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment. ~~The Department is proposing legislation to revise the copayment from \$50 to \$15 for non-emergency use of emergency rooms~~ **AB 1467 (Chapter 23, Statutes of 2012) stipulates that for the purposes of Medi-Cal copayments, an emergency service is defined as the treatment of an emergency medical condition or services that result in an inpatient admission.**

B 14 (PC-NA) X Pharmacy Copayments

This assumption has been moved to "Withdrawn" section.

B 15 (PC-NA) X X Eliminate ADHC Services

This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.

B 16 (PC-NA) X X Limit Enteral Nutrition to Tube Feeding

This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
B 17	(PC-35)	X	X	<u>Elimination of OTC Cough and Cold Products</u> AB 97 (Chapter 3, Statutes of 2011) eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children. Children eligible for EPSDT are exempt from this provision.
B 18	(PC-177)	X	X	<u>EPSDT Screens</u> The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.
B 19	(PC-181) (OA-65)	X	X	<u>CDDS Dental Services</u> The Lanterman Act requires the California Department of Development Services (CDDS) to provide dental services to its clients. Because Medi-Cal no longer covers most dental services for adults 21 years of age and older, CDDS has entered into an interagency agreement with the Department to have the Medi-Cal dental fiscal intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of processing claims and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012.
B 20	(OA-21)	X	X	<u>Prevention of Chronic Disease Grant Project</u> This assumption has been moved to "Affordable Care Act-Old Assumption" section.
B 21	(PC-133)	X	X	<u>Potentially Preventable Admissions</u> This assumption has been moved to "Managed Care: Old Assumption" section.
B 22	(OA-67)		X	<u>Quitline Administrative Services</u> Quitline provides a free telephone-based counseling program to help smokers quit. CMS is allowing the State to receive a 50% match of funds attributable to the administrative costs associated with Quitline providing services to Medicaid individuals. Since CDPH funds the helpline, the Department will claim the FFP and reimburse CDPH via an interagency agreement.
B 23	(PC-1)	X	X	<u>Family PACT Program</u> Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

been assumed for most family planning services, testing for sexually transmitted infections (STIs), and sterilizations. The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been assumed for the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons are assumed to be 13.95% of the Family PACT costs, as agreed upon by CMS, and are budgeted at 100% GF. Family PACT drugs will be included in the Medicaid Drug Rebate Program.

A State Plan Amendment (SPA), to replace the Family PACT waiver in accordance with the Federal Patient Protection and Affordable Care Act was approved on March 24, 2011. Under the SPA, effective retroactively to July 1, 2010, eligible family planning services and supplies formerly reimbursed with 100% General Funds will receive a 90% federal matching rate for certain eligible procedure codes, and family planning-related services will receive reimbursement at the State's regular FMAP rate.

B 24 (OA-22) X X Family PACT Evaluation
 (OA-69)

An important component of the Family PACT Program is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing: the changes in birth rates; access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.

A new contract to provide data, to monitor and evaluate the Family PACT program was negotiated for a five year term beginning July 1, 2010.

The Department budgets the Title XIX federal Medicaid funds for the contract. The matching GF is budgeted in the CDPH budget **in the FY 2012-13 Family PACT Evaluation policy change.**

~~Legislation is being proposed to transfer~~ **AB 1464 (Chapter 21, Statutes of 2012) transferred** the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 **in the FY 2012-13 Family PACT Evaluation policy change.**

B 25 (OA-27) X X Family PACT Support, Provider Education and Client Outreach
 (OA-70)

The Family PACT Program has two main objectives. One is to increase access to services in targeted populations of adolescents, males, and medically underserved women. The other is to increase the number of providers who serve these clients. Education and various support

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

services are provided to Family PACT providers and potential providers, as well as clients and potential clients. The Office of Family Planning contracts with a variety of entities to provide these services.

A contract to provide Family PACT support, provider education, and outreach was negotiated for a three-year term beginning April 1, 2009. **The Department has initiated a new procurement for these services.**

The Department budgets the Title XIX federal Medicaid funds for these activities. The matching GF is budgeted in the CDPH budget **for the FPACT Support, Provider Education & Client Outreach policy change.**

Legislation is being proposed to transfer **AB 1464 (Chapter 21, Statutes of 2012) transferred** the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 **in the Family PACT Program Administration policy change.**

B 26 (PC-FI) X X Family PACT Materials Distribution

An important component of the Family PACT Program is the distribution of client education materials to providers. The state, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 125 different publications.

B 27 (PC-FI) X X Family PACT Systems

The establishment of the Family PACT Program required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.

B 28 (OA-8) X X Family PACT HIPAA Privacy Practices Beneficiary Notification

Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a NPP to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees, and inform all beneficiaries about how to get a copy of this Notice at least every 3 years, or whenever a substantial change is made to the Notice. Due to confidentiality concerns, distribution of the NPP to these beneficiaries is accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 29	(PC-31)	X	X	<u>Increased Federal Matching Funds for FPACT</u>
<p>On March 24, 2011, CMS approved a State Plan Amendment (SPA) for the Family PACT Program, in accordance with the Federal Patient Protection and Affordable Care Act. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning related services will receive reimbursement at the State's regular FMAP rate, effective retroactively to July 1, 2010.</p>				

HOME & COMMUNITY BASED SERVICES:

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

The IHSS Program helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must be age 65 years of age or older, disabled, or blind. Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment;
- Development of an individualized service plan;
- Linkage and consultation;
- Assistance with accessing services;
- Crisis assistance planning;
- Periodic review.

Waivers

Medi-Cal operates and administers various home and community-based services (HCBS) waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary state plan services are less than the total cost incurred at the otherwise appropriate nursing facility plus state plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal, Assisted Living (ALW), Developmentally Disabled/Continuous Nursing Care (DD/CNC), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), HCBS Developmentally Disabled, San Francisco Community Living Support Benefit (CLSB), and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

HOME & COMMUNITY BASED SERVICES:

Assisted Living Waiver (ALW)

The ALW pays for assisted living, care coordination, community transition, translation/interpretation, and home modification in eight counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, and Alameda). Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE) or through home health agency staff while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 2,920 in 2012 and 3,700 in 2013. The waiver is approved from March 1, 2009 through February 28, 2014.

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A lawsuit was filed challenging elimination of ADHC (Darling et al. v. Douglas et al.), which resulted in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS to provide necessary medical and social services to individuals with intensive health care needs. CBAS became effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver. Former ADHC participants and new eligible participants who meet the more stringent CBAS eligibility standards receive CBAS services in approved CBAS centers. CBAS was provided through Medi-Cal FFS effective April 1, 2012. On July 1, 2012, CBAS transitioned into five County Organized Health System (COHS) managed care counties. Beginning October 1, 2012, CBAS services will also transition into Two-Plan and GMC managed care plans, as well as the remaining COHS plan, Gold Coast Health Plan. Medi-Cal FFS will continue provide CBAS to eligible participants residing in non-managed care counties, or to eligible participants who are exempted from or ineligible for enrollment in a managed care plan. There is no cap on enrollment into this waiver service.

In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC. Current enrollment is 136 and the waiver is approved from January 1, 2010 through December 31, 2014.

Nursing Facility/Acute Hospital (NF/AH) Waiver

The NF/AH Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who met the acute hospital, adult, or pediatric subacute, nursing facility, distinct-part nursing facility (NF) Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization. The waiver: 1) facilitates a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services, and 2) offers eligible Medi-Cal beneficiaries, who reside in the community, but are at risk of being institutionalized within the next 30 days, the option of utilizing the NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs. Current enrollment is 2,206 and the waiver is approved from January 1, 2012 through December 31, 2016.

HOME & COMMUNITY BASED SERVICES:

Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver

The DD/CNC Waiver provides 24-hour continuous skilled nursing care in home and community-based residential settings to persons with developmental disabilities who are medically fragile. The program currently assists approximately 45 individuals who reside in homes located in Desert Hot Springs, Fresno, Gardena, San Bruno, San Jose, Santa Rosa and Sylmar. Eligibility criteria requires that DD/CNC Waiver participants be Medi-Cal eligible, enrolled in, and certified by a Regional Center as having a developmental disability, exhibit medical necessity for 24-hour continuous skilled nursing care and free of any clinically active communicable disease. Participants must also meet specific minimum medical criteria. Approved capacity of unduplicated recipients for this waiver is 84 for the 2011 fiscal year. The waiver is approved from October 1, 2009 through September 30, 2012. However, California has requested to CMS that the DD/CNC waiver be merged with the NF/AH waiver.

San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements Assembly Bill 2968 (Chapter 830, Statutes of 2006) and will allow the San Francisco Department of Public Health to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco.
- Be at least age 21 years or over.
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations.
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting.
- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home delivered meals in DAH sites.

Approved capacity of unduplicated recipients for this waiver is 221 for 2012, 377 for 2013, and 417 for 2014. The waiver is approved from July 1, 2012 through June 30, 2017.

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

HOME & COMMUNITY BASED SERVICES:

Services provided include:

- Case management;
- Skilled nursing;
- Attendant care;
- Psychotherapy;
- Home-delivered meals,
- Nutritional counseling,
- Nutritional supplements;
- Medical equipment and supplies;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Financial supplements for foster care.

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Approved capacity of unduplicated recipients for this waiver is 4,410 in 2013 and 4,490 in 2014. The waiver is approved from January 1, 2012 through January 31, 2016.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with 41 local agencies statewide to provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these frail clients. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility. Services provided by MSSP include: adult day care / support center, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, communication services. Approved capacity of unduplicated recipients for this waiver is 16,335 in 2012 and 2013. The waiver is approved from July 1, 2009 through June 30, 2014.

Developmentally Disabled (DD) Waiver

The DD Waiver provides home and community-based services to developmentally disabled persons who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of a intermediate care facility for the mentally retarded (ICF/MR); in California, they are the Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is 105,000 in 2012 and 110,000 in 2013. The waiver is approved from October 1, 2011 through September 30, 2016.

HOME & COMMUNITY BASED SERVICES:

Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and Family Unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009 through March 31, 2012. The state submitted a waiver renewal application, which is pending approval. Currently, the waiver is under extension through September 2012 as the state responds to the Centers for Medicare & Medicaid Services' Request for Additional Information. Upon approval, the waiver term will be April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

Managed Care Programs

Program for All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers integrated services including medical, dental, vision and other specialty services to beneficiaries who would otherwise be in an intermediate care facility or in skilled nursing. Participants must be 55 years or older and meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place. There are five PACE organizations who collectively serve over 3,100 Californians at a total of 24 PACE centers.

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, and San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. The number of unduplicated participants is 7,182 in 2012. The contract will end December 31, 2013.

Special Grant

Community Care Transitions (CCT)/Money Follows the Person Grant

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act, and is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and

HOME & COMMUNITY BASED SERVICES:

implement strategies to assist 6,177 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings. Approved capacity of unduplicated recipients for this waiver is 543 in 2012, 1,044 in 2013, and 1,268 in 2014. The waiver is approved from January 1, 2007, through September 30, 2016.

HOME & COMMUNITY BASED SERVICES: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
H 0.1 (PC-200)	X	X	<p><u>Reduction in IHSS Authorized Hours</u></p> <p>SB 73 (Chapter 34, Statutes of 2011) imposed a 20% service hour reduction on IHSS recipients effective January 1, 2012, when the 2011-12 Budget "Trigger Reductions" became operative. Individuals receiving IHSS hours through a 1915(c) waiver would be exempt. The bill also established an IHSS Care Supplement process for any individual who is notified of a reduction in service hours, but is believed to be at serious risk of out-of-home placement unless all or part of the reduction was restored. The IHSS Care Supplement process requires the individual to submit an application to the county to determine risk. The county would determine whether IHSS hours will be partially or fully restored to avoid risk of out-of-home placement.</p> <p>The Department submitted to CMS a SPA with an effective date of April 1, 2013. A court order issued on March 2, 2012 (<i>David Oster et al. v. Lightbourne and Douglas</i>) enjoined the Department and CDSS from implementing provisions of SB 73.</p>
H 0.2 (PC-201)	X	X	<p><u>3.6% IHSS Reduction</u></p> <p>AB 1612 (Chapter 725, Statutes of 2010), enacted a 3.6% reduction of IHSS service hours. Recipients may determine which of their services will be impacted by the reduction. CDSS implemented this reduction on February 1, 2011. This reduction will sunset June 30, 2013.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y

C/YB/Y

H 1

Home and Community-Based Services

Home and Community-Based Services (HCBS) are services designed to keep persons needing long-term care supported and safe in their homes or other community settings, in lieu of placing them in long-term care facilities like nursing homes, subacute or acute care hospitals, and intermediate care facilities for persons with developmental disabilities, or State Developmental Centers. HCBS also provide support for residents in long-term care facilities to return to their homes or communities.

HCBS encompass State Plan services, including Personal Care Services provided through CDSS' In-Home Supportive Services program and Adult Day Health Care; which ~~will be~~ **was** eliminated on ~~February 29, 2012~~ **March 31, 2012** and replaced by Community-Based Adult Services. Full risk managed care services are also provided through Programs of All-inclusive Care for the Elderly (PACE) and Senior Care Action Network (SCAN); an eight-year federal demonstration to transition LTC facility residents back to their homes and communities. Several different waiver programs provide a range of services like private duty nursing, personal care, case management, habilitation, emergency response systems, respite, and home modifications for accessibility and safety.

(PC-169) X

X

A. Home and Community Based Services— CDDS

This waiver serves persons with developmental disabilities who are regional center clients and reside in community settings instead of intermediate care facilities for the developmentally disabled.

~~CMS approved the renewal of the waiver for another five years, effective October 1, 2006 through September 30, 2011. The enrollment cap for the first year of the waiver was 75,000, and the cap will increase to 95,000 by the fifth year. On June 29, 2011, the Department submitted a waiver renewal application to CMS for the term of October 1, 2011 through September 30, 2016.~~ **CMS approved an extension of the waiver for the term of October 1, 2011 through September 30, 2016.**

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
	(PC-24) (OA-59)	X	X	<p>B. <u>Multipurpose Senior Services Program – CDA</u></p> <p>On June 23, 2009, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver for the period of July 1, 2009 through June 30, 2014. Under the waiver, CDA contracts with local government or nonprofit agencies to provide waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would otherwise require care in a nursing facility. MSSP services include health care and personal care assistance, respite care, housing assistance, meal services, transportation, protective services, emergency response systems, and chore services.</p> <p>The Department pays the MSSP claims. The GF is budgeted in the CDA budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay the MSSP claims. The budgeted amount for FY 2011-12 and 2012-13 includes savings from a permanent reduction to the MSSP.</p> <p><u>On June 1, 2013, in the counties participating in the CCI Duals Demonstration, managed care health plans will contract with existing MSSP sites for care management services consistent with the plans' Model of Care.</u></p>
H 2	(PC-NA)	X	X	<p><u>In-Home Operations Waiver</u></p> <p>CMS approved the IHO Waiver renewal effective January 1, 2010 through December 31, 2014. The IHO Waiver “grandfathered in” Medi-Cal beneficiaries who were continuously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and continue to receive direct-care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care (LOC) cost cap under the NF/AH Waiver. Each IHO participant’s LOC and waiver costs will remain the same as previously authorized.</p>
H 3	(PC-179)	X	X	<p><u>Waiver Personal Care Services</u></p> <p>AB 668 (Chapter 896, Statutes of 1998) requires Medi-Cal to add waiver personal care services (WPCS) to NF A/B and NF SA Levels of Care. This service is not available to those individuals at the Hospital LOC due to their extensive medical needs. WPCS is one option on the Menu of Health Services (MOHS) that NF/AH and IHO waiver participants may choose from, to the extent that waiver cost neutrality is assured.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 4	(PC-166) (OA-52)	X	X	<p><u>Personal Care Services</u></p> <p>As of April 1993, the Medi-Cal program has covered covers personal care services as a benefit. This is accomplished by making Title XIX funds available to the IHSS program under the administrative control of CDSS.</p> <p>CMS revised its interpretation of the State Plan Personal Care Services Program (PCSP) to include protective supervision and domestic and related services, effective August 1, 2004.</p> <p>Legislation is being proposed to mandatorily enroll dual eligible <u>SB 1036 (Chapter 45, Statutes of 2012) requires mandatory enrollment of dual eligibles in eight counties</u> into managed care for their Medi-Cal benefits, <u>including their IHSS benefit</u>. Those benefits include IHSS; see policy change Transition of Dual Eligibles-LTC for more information. IHSS costs are currently budgeted in this policy change, but due to the transitions of IHSS recipients to managed care, <u>The transition will occur between March 2013 and June 2013. As this transition occurs,</u> IHSS costs will be paid through managed care capitation beginning March 1, 2013. IHSS costs related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.</p>
H 5	(PC-25) (PC-26) (PC-38) (OA-36)	X	X	<p><u>California Community Transitions (CCT)</u></p> <p>In January 2007, CMS awarded the Department a Money Follows the Person Rebalancing Demonstration Grant for \$130 million in federal funds. The demonstration, called California Community Transitions, is effective from January 1, 2007 through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings. The revised award is \$104 million in federal funds.</p> <p>During the 12 months a participant is enrolled in the demonstration, the Department will receive enhanced FFP for the provision of certain HCB services approved by CMS. After 12 months, participants are disenrolled from the demonstration, but will continue to receive HCBS under the State Plan or via an appropriate HCBS waiver for which they are eligible. Transition work began in September 2008.</p> <p>The Department established IAs with CDDS and CDSS to provide enhanced FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 6	(PC-NA)	X	X	<u>AIDS Waiver</u>
This assumption has been moved to the "HCBS Introduction" section.				
H 7	(OA-53)	X	X	<u>Health-Related Activities</u>
Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.				
H 8	(PC-16) (OA-59)	X	X	<u>Adult Day Health Care — CDA Department of Aging – Administrative Costs</u>
<p>ADHC is a community-based day program providing a variety of health, therapeutic, and social services designed to serve those at risk of institutionalization. ADHC became an optional Medi-Cal benefit in 1978. ADHC rates are adjusted effective August 1 of each year based on the weighted average NF-A increase. The ADHC program was to be eliminated effective December 1, 2011 pursuant to AB 97 (Chapter 3, Statutes of 2011).</p> <p>The Department settled the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of the optional ADHC benefit. Under the settlement, the ADHC benefit will be extended until February 29, 2012. The federal government later approved to further extend the ADHC benefit until March 31, 2012 per the Department's request.</p> <p><u>The federal government provides Title XIX federal financial participation to the California Department of Aging for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services and the Multipurpose Senior Services Program.</u></p>				

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y				
		<u>C/Y</u>	<u>B/Y</u>	
H 9	(PC-115)	X	X	<p><u>PACE: Program of All-Inclusive Care for the Elderly</u></p> <p>The Department contracts with five PACE organizations in various counties for risk-based capitated care of the frail elderly. PACE programs provide all medical services, home and community-based long-term care (including adult day health care and in-home support) to Medi-Cal and Medi-Cal/Medicare <u>(dual eligible)</u> beneficiaries who are determined by the Department to be at the skilled nursing or intermediate care facility level of care. PACE rates are based upon <u>historical</u> Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits. PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. The 2011 rates are calculated using the Upper Payment Limit (UPL) for each year including 2011. The 2012 and 2013 rate setting methodology will use a mix of IHSS and long-term care facility actual cost-based data. Six <u>Four</u> new PACE organizations will become operational in FY 2012-13 <u>and one additional organizations will begin in FY 2013-14.</u></p>
H 10	(PC-118) (PC-129)	X	X	<p><u>Senior Care Action Network</u></p> <p>The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach and coordinates and provides services in designated areas of Los Angeles, San Bernardino, and Riverside counties. The Department received approval from CMS to prepare a comprehensive risk managed care contract authorized under 1915a to fund State Plan Only Medi-Cal services to its members. SCAN provides medical, social, and case management services to Medicare beneficiaries ages 65 and over in Medi-Cal's aged, disabled, and long term care aid group categories (dual eligibles). All necessary medical services are provided by SCAN. Enrollees who are <u>certifiable for skilled nursing facility (SNF) or intermediate care facility (ICF) certifiable levels of care</u> are eligible for additional HCBS. SCAN holds a five-year contract with the Department. The term of the current SCAN contract is January 1, 2008 through December 31, 2012. <u>The Department does not plan to renew the SCAN contract. A one-year extension for January 1, 2013 through December 31, 2013 has been executed to facilitate transition of the SCAN Medi-Cal population to existing Medi-Cal programs.</u></p> <p>Rates are determined by federal law on an actuarially sound basis. In addition, California state law requires that rates be no more than the rates determined on a FFS equivalent basis. Beginning January 1, 2009, SCAN's rates are re-determined on a calendar year basis to coincide with the time period covered by its contract. To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. Rates through 2012 will be **2013 are** developed based on the plans' actual experience. ~~FY 2011-12 and 2012-13 funding includes projected costs for the annual rate redetermination.~~ AB 1422 (Chapter 175, Statutes of 2009) imposed an additional tax (Gross Premium tax) on the total operation revenue of Medi-Cal Managed Care plans. Beginning January 1, 2010, the Gross Premium tax revenue was incorporated into the SCAN rates retroactive to January 1, 2009. ~~The Gross Premium tax was extended to June 30, 2011. ABX1-21 (Chapter 11, Statutes of 2009) extended the Gross Premium tax through June 30, 2012 is expected to be extended to June 30, 2014.~~

H 11 (OA-41) X X Pediatric Palliative Care Waiver

AB 1745 (Chapter 330, Statutes of 2006) required the Department to submit an application to CMS for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver was approved on December 3, 2008 for three years, beginning April 1, 2009 through March 31, 2012. The waiver was implemented and began enrollment on January 1, 2010. The Department has submitted a waiver renewal application to CMS for the period of April 1, 2012 through March 31, 2017. **CMS has requested changes to the current waiver. The waiver is operating under a temporary extension through September 30, 2012. It is anticipated that the renewal will be approved after the required changes are made.**

The waiver makes available services comparable to those available through hospice that can be provided at the same time that the child would receive curative services.

The legislation mandates the Department to evaluate the pilot project. An independent evaluation of the waiver is also required to meet federal assurances. The evaluation began in July 2010.

H 12 (PC-28) X X SF Community-Living Support Benefit Waiver

The San Francisco (SF) Community- ~~Supported~~ **Living Support Benefit** Waiver implements AB 2968 (Chapter 830, Statutes of 2006), which requires the Department to develop and implement a community-living support benefit for Medi-Cal beneficiaries 21 years of age and older, residing in the City and County of SF who would otherwise be residing in nursing facilities or be rendered homeless. ~~In the proposed new waiver, the~~ **The Department is working worked** with the SF Department of Public Health to ~~propose service delivery~~ **develop this waiver** under a **the** 1915(c) HCBS waivers.

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

Eligible participants will have full-scope Medi-Cal or share-of-cost Medi-Cal for services to be rendered in Residential Care Facilities for the Elderly (RCFEs), **Adult Residential Facilities**, or in residency units made available by the Direct Access to Housing (DAH) program.

The City and County of San Francisco will pay for the non-federal share of the waiver costs. ~~A draft waiver application is pending with CMS. The Department will utilize~~ **through the utilization of** CPEs to obtain federal funding for this project. **On May 22, 2012, CMS approved the waiver with an effective date of July 1, 2012 through June 30, 2017.**

H 13 (PC-22) X
 (Reworded)

X

Additional Services for HCBS Clients

The Department submitted a 1915(i) Home and Community-Based Services (HCBS) state plan amendment (SPA) to CMS in December 2009. The SPA requests inclusion of certain services provided by the State's Regional Center (RC) network of non-profit providers to persons with developmental disabilities. RC clients who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include: habilitation, respite care, personal care services, homemaker services, and home health aide services. Approval of the SPA is expected in FY 2012-13, with a retroactive date of October 1, 2009. ABX3 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. The SPA proposes to restore reimbursement for the eliminated services rendered in FY 2010-11 and forward. This will enable persons with developmental disabilities access to HCBS State Plan benefits, other community services, activities, and resources.

A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011.

In June 2012, an additional SPA was submitted to CMS to allow participants to self-direct selected HCBS under the 1915(i) program retroactive to April 1, 2012.

H 14 (OA-36) X

X

CCT Enrollment-Administrative Costs

Pursuant to the Patient Protection and Affordable Care Act, the Department applied for and was awarded grant funding to cover administrative costs needed to increase California Community Transitions (CCT) participation. The grant requires the Department to foster collaborations between the existing Aging and Disability Resource Connection (ADRC) programs and CCT lead organizations to increase

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				CCT enrollment. The costs incurred for these activities are 100% federally funded.
H 15 (PC-29)	X	X		<u>Quality of Life (QoL) Surveys for Money Follows the Person Program Participants</u> CMS requires the Department to conduct QoL surveys with CCT participants within specified timeframes and follow a specific methodology. CCT lead organizations, which are Medi-Cal home and community-based services waiver providers, conduct QoL surveys designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The costs of conducting the surveys are 100% federally funded.
H 16 (OA-NA)	X	X		<u>Administrative Costs for CCT</u> This assumption has been moved to "Withdrawn" section.
H 17 (PC-32) (PC-FI) (OA-25)	X	X		<u>ADHC Transition</u> AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. As a result of the settlement of the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of ADHC services, the ADHC benefit was extended until March 31, 2012. Beginning Effective April 1, 2012, the ADHC program will end as an optional Medi-Cal benefit and a new program called Community-Based Adult Services (CBAS) will be was made available to eligible individuals under the Medi-Cal Fee-For-Service (FFS) program. Beginning On On July 1, 2012, CBAS services will transition transitioned into five County Organized Health Systems (COHS) managed care counties. Effective October 1, 2012, CBAS will also transition into Two-Plan managed care and Geographic Managed Care plans, as well as the remaining COHS plan. and the The costs will be built into the capitation rate at the actuarial equivalent. For those CBAS eligible beneficiaries residing in geographic areas where managed care is not available, Medi-Cal FFS will provide CBAS coverage. CBAS eligible beneficiaries in managed care counties who do not qualify for managed care enrollment or have an approved medical exemption will be eligible to receive CBAS services if a CBAS Center is available in their geographic area, or Enhanced Case Management (ECM) services unbundled CBAS if there are no CBAS Centers in their geographic areas.

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

Beneficiaries not eligible for CBAS services ~~may be~~ **who received ADHC services between July 1, 2011 and February 29, 2012 are** eligible for Enhanced Case Management (ECM) services through Medi-Cal FFS or a Medi-Cal Managed Care Health Plan.

~~As stipulated in the settlement, the~~ **The** Department will develop has developed and ~~send out~~ mailed beneficiary notices informing beneficiaries of their eligibility for CBAS services, how to receive CBAS services, and ~~how to receive other services such as ECM~~ for beneficiaries that are not eligible for CBAS, how to receive other services such as ECM.

There will be associated costs to the State due to the special mailings/letters, updates to informing material packets, and provider directories.

H 18 (PC-173) X Community First Choice Option

This assumption has been moved to "Affordable Care Act-Old Assumption" section.

H 19 (PC-NA) X Trigger Cuts to CDSS for IHSS

This assumption has been moved to "Withdrawn" section.

FAMILY PACT: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

FAMILY PACT: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FP 1	(PC-1)	X	X	<u>Family PACT Program</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 2	(OA-22) (OA-69)	X	X	<u>Family PACT Evaluation</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 3	(OA-27) (OA-70)	X	X	<u>Family PACT Support, Provider Education and Client Outreach</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 4	(PC-FI)	X	X	<u>Family PACT Materials Distribution</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 5	(PC-FI)	X	X	<u>Family PACT Systems</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 6	(OA-61)	X	X	<u>CDPH I&E Program and Evaluation</u> The assumption has been moved to the "Reimbursements: Old Assumption" section.
FP 7	(OA-8)	X	X	<u>Family PACT HIPAA Privacy Practices Beneficiary Notification</u> The assumption has been moved to the "Benefits: Old Assumption" section.
FP 8	(PC-31)		X	<u>Increased Federal Matching Funds for FPACT</u> The assumption has been moved to the "Benefits: Old Assumption" section.

BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

BC 1 (PC-3) X X Breast and Cervical Cancer Treatment Program

The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income at or below 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a state-funded program that provides cancer and cancer-related treatment services only to persons not eligible for Medi-Cal. The state-funded program is 100% GF, but may receive Safety Net Care Pool funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, women over the age of 65, undocumented women of any age, and males are eligible for the state funded program. Undocumented women under age 65 are also eligible for federally funded emergency services and pregnancy-related and state-only long-term care services for the duration of their cancer treatment.

Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. DHCS Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.

With additional staffing, the Department began processing annual redeterminations. Redeterminations are done for beneficiaries in the BCCTP federally-funded aid codes, as well as for those in the BCCTP State-funded aid codes who receive federally-funded emergency coverage. Those persons determined no longer BCCTP program eligible are referred to the counties to determine if they are eligible for any other Medi-Cal program. For those determined by the counties not to be eligible for any other Medi-Cal program, a determination will be made if they are eligible for the State-funded BCCTP.

Current managed care rates fully incorporate BCCTP costs.

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
BC 2 (PC-3)	X	X		<u>Breast and Cervical Cancer Treatment Program – Premium Payment</u>
				<p>Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and/or cervical cancer who have other health insurance but are underinsured. Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer. The criteria for participation in the state funded premium payment program include the following:</p> <ul style="list-style-type: none"> • Family income at or below 200% of FPL as determined by the enrolling provider, • California resident, • Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination, • Diagnosis of breast and/or cervical cancer and in need of treatment, • Not eligible for full-scope, no cost Medi-Cal
BC 3 (OA-8)	X	X		<u>BCCTP Postage and Printing</u>
				<p>Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program are budgeted in local assistance, including postage-paid return envelopes for counties to mail copies of DRA/citizenship documentations received from BCCTP beneficiaries. Costs for the state funded component of the program are 100% General Fund, and are included in the Postage and Printing policy change. Mailings include annual redetermination packets to beneficiaries in the federal BCCTP program, retroactive Medi-Cal applications, letters to all applicants to request additional information, notices of approval or denial of eligibility, and referral packets to the counties for redetermination under other Medi-Cal programs as required under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.</p>

PHARMACY: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
PH 1	(PC-168)	X	X	<u>Part D–Phased-Down Contribution</u>
				This assumption has been moved to “Other: Reimbursement: Old Assumption” section.
PH 2	(PC-43)	X	X	<u>Non FFP Drugs</u>
				Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with CMS. The Department has established claiming procedures to ensure that FFP is claimed correctly. Effective March 2007, an automated quarterly report identifies the costs of drugs for which there is no FFP. This report is used to reduce the FFP. In October 2010, an analysis of the non-FFP drug reports determined that these reports were not accurately capturing non-FFP drug claims. The reports were revised and then re-run for the period FY 2004-05 through FY 2009-10. As a result, a larger number of claims were identified as being ineligible for FFP. The Department will reimburse CMS for the identified non-FFP drug costs, retroactive to FY 2004-05.
PH 3	(PC-47)	X	X	<u>Family PACT Drug Rebates</u>
				The Department collects rebates for family planning drugs covered through the Family PACT program.
				The Department began invoicing for Family PACT drug rebates on June 7, 2001. These invoices covered all quarters back to December 1, 1999.
				Beginning October 2008, the Department no longer collects rebates for drugs that are not eligible for FFP.
PH 4	(PC-49)	X	X	<u>State Supplemental Drug Rebates</u>
				The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.
PH 5	(PC-52)	X	X	<u>Federal Drug Rebate Program</u>
				Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states’ coverage of manufacturers’ drug products. The manufacturers have 38 days to make payment after being billed.

PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
PH 6 (PC-45)	X	X		<u>Medical Supply Rebates</u>
				<p>The Department negotiates diabetic medical supply rebates with diabetic supply manufacturers to provide savings to the Department. Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are sent quarterly to manufacturers.</p> <p>The product reimbursement rates for diabetic supply products are based on the contracted Maximum Acquisition Cost (MAC). Reimbursement on the MAC has resulted in additional savings to the Department.</p> <p>On December 31, 2012, MAC contracts (those with and without rebates) for diabetic supplies will expire. The Department will negotiate terms to reduce net costs for contracts effective January 1, 2013.</p>
PH 7 (PC-48)	X	X		<u>Aged and Disputed Drug Rebates</u>
				<p>The Department collects drug rebates as required by federal and state laws. The Department has completed its work on the oldest aged rebate disputes (1991-96) and is awaiting final agreements from a few pharmaceutical companies, which account for the majority of the amount in dispute, before closing out the time period. The Department has begun work on disputes for the 1997-2002 time period.</p> <p>Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and to receive rebate payments.</p> <p>Collection and closure of outstanding disputes has been slowed and workload increased at times due to a few large disputes with several large pharmaceutical manufacturers who have hired contractors to dispute payments made during these years.</p>
PH 8 (OA-43)	X	X		<u>Epocrates</u>
				<p>The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates provides the Department with an opportunity to reach a large network of health professionals via a point-of-care clinical reference for physicians and other health professionals. Epocrates' formulary is free to health professional users.</p>
PH 9 (PC-44)	X	X		<u>BCCTP Drug Rebates</u>
				<p>Enhanced Title XIX Medicaid funds (65% FFP/35% GF) are claimed for drugs under the federal Medicaid BCCTP program. The Department is</p>

PHARMACY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

required by federal law to collect drug rebates whenever there is federal participation. Beginning January 2010, the Department is collecting drug rebates for the federal BCCTP program. Manufacturers were invoiced retroactively to January 1, 2002. By agreement with CMS, rebates for beneficiary drug claims for the federal portion of the BCCTP program (emergency and prenatal services) for those without satisfactory citizenship or immigration status will not be invoiced.

PH 10 (PC-46) X X Physician-Administered Drug Reimbursement

The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. SB 853 (Chapter 717, Statutes of 2010) established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with Medi-Cal rates of payment for non-physician-administered pharmaceuticals beginning January 2011. **the Medicare rate of reimbursement or the pharmacy rate when the Medicare rate is not available.** The new methodology is expected to generate savings beginning in April 2012 for claims from September 2011 and ongoing. To ensure these rates are in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology. **Upon implementation of the new rates in October 2012, the new methodology is expected to generate savings. Erroneous Payment Corrections will be performed from September 1, 2011 forward on all claims that were reimbursed under the old methodology.**

PH 11 (OA-31) X X Rate Studies for MAIC and AAC Vendor

Welfare and Institutions Code, Section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. AB 102 (Chapter 29, Statutes of 2011) authorized the Department to develop a new reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price (AWP). In order to obtain the information from providers necessary to establish the MAICs and AACs, the Department will hire a contractor **in FY 2012-13** to survey drug price information from the Medi-Cal pharmacy providers and update AACs and MAICs on an ongoing basis. Currently, the Department is subject to a court injunction which precluded implementation of the MAIC methodology, as amended by ABX4 5 (Chapter 5, Statutes of 2009). However, MAICs based on the new reimbursement benchmark, AACs, are not subject to that injunction.

PH 12 (PC-41) X X Federal Drug Rebate Change

This assumption has been moved to "ACA – Old Assumptions" section.

PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PH 13 (PC-51)			X	<u>Managed Care Drug Rebates</u> This assumption has been moved to "ACA – Old Assumptions" section.
PH 14 (PC-NA)	X		X	<u>EPC for Average Wholesale Price Frozen Rates</u> This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.
PH 15 (PC-42)	X		X	<u>Kalydeco for Treatment of Cystic Fibrosis</u> Effective January 31, 2012, the U.S. Food and Drug Administration approved Kalydeco for the treatment of patients, six years and older, with cystic fibrosis (CF) who have a specific mutation in the CF regulator gene.

DRUG MEDI-CAL: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

D 0.1 (PC-59) X X Drug Medi-Cal Program Cost Settlement

The Drug Medi-Cal program reimburses counties and contracted providers for the alcohol and drug treatment services that they provide to Drug Medi-Cal beneficiaries. The Drug Medi-Cal program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the rate cap. At the end of each fiscal year, non-Narcotic Treatment Program (non-NTP) providers must submit actual cost information. The Drug Medi-Cal program completes a final settlement after receipt and review of the provider's cost report.

Reimbursement for non-Narcotic Treatment Program providers is limited to the lowest of the following costs:

- Provider's usual and customary charges to the general public for the same or similar services,
- Provider's allowable costs, or
- Drug Medi-Cal statewide maximum allowance for each non-NTP service modality.

Reimbursement to Narcotic Treatment Program providers is limited to the lowest of the following costs:

- Provider's usual and customary charges to the general public for the same or similar services,
- Drug Medi-Cal uniform statewide daily reimbursement rate for the service.

D 0.2 (PC-58) X X Annual Rate Adjustment

The Department annually adjusts the Drug Medi-Cal Rate based on the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies. The annual rate adjustment is effective July 1st of each year.

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
D 1	(PC-56)	X	X	<p><u>Perinatal Residential Substance Abuse Services</u></p> <p>The Perinatal Residential Substance Abuse Services program provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnoses in a non-institutional, non-medical, residential setting. Each beneficiary resides on the premises and receives support in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. The cost of room and board is not reimbursed under the Medi-Cal program.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 2	(PC-55)	X	X	<p><u>Day Care Rehabilitative</u></p> <p>Day Care Rehabilitative services provide outpatient counseling and rehabilitation services at least three hours per day, three days per week to persons with substance use disorder diagnoses,</p> <ul style="list-style-type: none"> • who are pregnant or in the postpartum period, • and/or to EPSDT eligible beneficiaries. <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 3	(PC-54)	X	X	<p><u>Outpatient Drug Free Treatment Services</u></p> <p>The Outpatient Drug Free (ODF) Treatment program is designed to stabilize and rehabilitate persons with substance use disorder diagnoses in an outpatient setting when prescribed by a physician as medically necessary. Each ODF participant receives at least two group counseling sessions per month. Face-to-face counseling is limited to intake, crisis intervention, collateral services, and treatment and discharge planning.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 4	(PC-53)	X	X	<p><u>Narcotic Treatment Program</u></p> <p>The Narcotic Treatment Program provides outpatient methadone or LAAM (not currently manufactured) services directed at stabilization and rehabilitation of persons with opioid dependency and diagnoses of substance use disorder.</p> <p>The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes of face-to-face</p>

DRUG MEDI-CAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

counseling sessions. The Narcotic Treatment Program does not include detoxification.

Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.

D 5 (PC-57)

Naltrexone Treatment Services

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and diagnoses of substance use disorder. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.

Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.

MENTAL HEALTH: NEW ASSUMPTIONS

Applicable F/Y		
<u>C/Y</u>	<u>B/Y</u>	
MH 0.1 (OA-48)	X	<u>PASRR</u> QTC Medical Group, Inc. completes Level II evaluations for the federally mandated Preadmission Screening and Resident Review (PASRR) program. QTC provides licensed clinical evaluators to conduct a face-to-face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. QTC enters Level II findings into the PASRR database. The currently contract ends in June 2014. The FY 2012-13 budget is included in support, but beginning with FY 2013-14 it will be part of local assistance estimate.
MH 0.2 (PC-204) X	X	<u>Elimination of State Maximum Rates</u> Assembly Bill 1297 (Chapter 651, Statutes of 2011) eliminated the state maximum rates paid for Medi-Cal specialty mental health services. AB 1297 requires the Department to reimburse mental health plans based upon the lower of their certified public expenditures or the federal upper payment limit. The federal upper payment limit will be equal to the aggregate allowable cost or customary charge for all specialty mental health services provided by the mental health plan and its network of providers.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 1 (PC-60)	X	X	<p><u>Children, Adult, and FFS Psychiatric Inpatient</u></p> <p>Children: Medi-Cal provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to children and young people, under 21 years of age. The program includes services required to correct or improve medical problems diagnosed by a doctor or health care provider.</p> <p>Adult: The Short-Doyle Act organizes and finances community mental health services for persons with mental illness through locally administered and locally controlled community health programs.</p> <p>FFS Psychiatric Inpatient Hospital: Medi-Cal provides psychiatric inpatient hospital services to enrollees 21 years of age and older with specified diagnoses requiring inpatient hospital treatment. Enrollees must have:</p> <ul style="list-style-type: none"> • An eligible mental health diagnosis, • Evidence of significant impairment or deterioration, and • Be expected to improve with intervention. <p>Effective July 1, 2012, the DMH program staff and associated funding was shifted to the Department.</p>
MH 2 (PC-62)	X	X	<p><u>Healthy Families Program SED</u></p> <p>The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:</p> <ul style="list-style-type: none"> • Do not have insurance, • Do not qualify for zero share of cost Medi-Cal, and • Income is at or below 250 percent of the federal poverty level. <p>Mental health services for the HFP subscribers who are Seriously Emotionally Disturbed (SED) are “carved-out” of the HFP health plans’ array of covered services and are provided by county mental health departments. County mental health departments are responsible for the provision and payment of all treatment of SED conditions, with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HFP health plan. This covered benefit is referred to as the “HFP SED benefit.”</p> <p>When a mental health department assumes responsibility for the treatment of the HFP enrollee’s SED condition, it claims for the services. County mental health departments receive 65% federal FFP reimbursement for services provided to HFP subscribers and pay for the 35% match with realignment dollars or other local funds.</p>

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Effective July 1, 2012, the DMH functions related to the HFP SED Benefit and associated funding was shifted to the Department.

~~Effective~~ **No sooner than** January 1, 2013, the HFP will cease to enroll new ~~applicants~~ **subscribers** and HFP ~~enrollees~~ **subscribers** will transition into Medi-Cal through a phase-in methodology. ~~Children enrolled in the HFP will be transitioned to the Medi-Cal Program as targeted low-income children.~~

MH 3 (PC-69) X X IMD Ancillary Services
 (PC-70)

Effective July 1, 1999, the cost of ancillary services for Medi-Cal ~~eligibles, 21 years of age and older or who have not attained 65 years of age and who are residents of CDMH~~ **beneficiaries who are ages 22 through 64 residing in** Institutions for Mental Diseases (IMDs), was entirely state-funded. ~~As of In 2008, this the entire cost is now county-funded~~ **became a county responsibility.**

MH 4 (PC-68) X X Siskiyou County Mental Health Plan Overpayment

~~The Department of Mental Health (DMH) has identified overpayments to Siskiyou County Mental Health Plan (MHP) due to inappropriate Medi-Cal billing practices. The overpayment amounts were identified through the cost settlement and fiscal audits processes. The Department must return the overpaid FFP reimbursements to the CMS.~~ **Siskiyou County and the State are currently negotiating a plan for the county to reimburse the State for the repayment.**

MH 5 (PC-72) X X Interim and Final Cost Settlements—Specialty Mental Health Services
 (OA-11)

Within two years following the end of a fiscal year, the Department must reconcile interim settlements to MHPs for children, adults, and healthy families specialty mental health services to county cost reports and process correcting payments or recoupments.

MH 6 (PC-71) X X Chart Review

The Department conducts on-site chart reviews by comparing claims to the corresponding patient chart entries.

MH 7 (PC-67) X Specialty Mental Health Lawsuits

Three Los Angeles MHPs have filed a writ of mandate requesting the court to direct the Department to approve certain Specialty Mental Health claims from FY 1999-00 and FY 2000-01. The cases are referred to as:

- *Hillsides Home for Children, et al. v. California, et al,*
- *Hathaway-Sycamores Child and Family Services, et al. v. California, et al, and*

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- *Five Acres v. California, et al*

The claims were denied for various reasons including lack of Medi-Cal eligibility on the date of service. A proposed settlement agreement provides for Los Angeles County to pay the providers for the claims, certify the public expenditures, and submit the claims to the Department for FFP.

MH 8 (PC-65) X X Solano County

Prior to FY 2012-13, the Medi-Cal managed care program “carved in” specialty mental health services for Solano County.

Under the 2011 Realignment, Solano County decided to exercise their right to assume responsibility for providing or arranging for the specialty mental health services from the Medi-Cal Managed Care Plan, effective July 1, 2012.

The Medi-Cal Managed Care contract will be reduced for the mental health services component and the mental health managed care funding to Solano County will increase by the same amount.

MH 9 (PC-66) X X Over One-Year Claims

County MHPs have begun submitting Medi-Cal specialty mental health service claims for clients with Letters of Authorization for late eligibility determinations. When an over one-year claim is determined as eligible by the Department, the county has 60 days to submit the claim for payment.

MH 10 (OA-3) X X County Specialty Mental Health Administration

Counties may obtain federal reimbursement for certain costs associated with administering a county’s mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

MH 11 (OA-10) X X County Utilization Review and Quality Assurance

County Utilization Review (UR) and Quality Assurance (QA) activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 50% or 75% depending on the claim.

MH 12 (OA-44) X X Katie A. v. Diana Bontá – Special Master
(PC-63)

On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of EPSDT program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service **effectively**. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. **On October 13, 2011**, the parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation. The Special Master is being funded by the Department and CDSS. **As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner.**

1115 WAIVER—MH/UCD & BTR

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and a new demonstration was approved by CMS.

The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) was approved effective November 1, 2010, for five years. This Demonstration extends and modifies the previous MH/UCD. Many of the features of the previous Demonstration have been continued with modifications as noted in the individual assumptions. There is no new funding for the South LA Preservation Fund and the Distressed Hospital Fund. Other significant changes in the new Demonstration are:

- Expansion of the state-only programs that may be federalized up to a maximum of \$400 million in each year of the waiver;
- Creation of a Delivery System Reform Incentive Pool (DSRIP) fund to support public hospital efforts in enhancing quality of care and health of patients;
- Expansion of the current Health Care Coverage Initiative (HCCI) by creating a separate Medicaid Coverage Expansion (MCE) program using new funding for those eligibles who have family income at or below 133% of the Federal Poverty Level.

1115 WAIVER—MH/UCD & BTR: NEW ASSUMPTIONSApplicable F/Y
C/Y B/Y

W 0.1 (PC-101) (PC-FI)	X	X	<u>Diagnosis Related Group – Inpatient Hospital Payment Methodology</u> SB 853 (Chapter 717, Statutes of 2010) mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon diagnosis related groups (DRGs). The DRG payment methodology will replace the previous payment methods. For contract hospitals, DRGs will replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs will replace the previous cost-based reimbursement methodology. DRG implementation is scheduled to begin July 1, 2013. The Medi-Cal Fiscal Intermediary, Xerox State Healthcare, LLC (Xerox), will implement California Medicaid Management Information Systems (CA-MMIS) changes to comply with this legislation.
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1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 1	(PC-77) (PC-90)	X	X	<p><u>MH/UCD & BTR—Safety Net Care Pool</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions (STCs) of the MH/UCD, a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503.</p> <p>The federal funds that the Department claims from the SNCP are based on the following Certified Public Expenditures (CPEs):</p> <ul style="list-style-type: none"> • The CPEs of the Designated Public Hospitals (DPHs). • The CPEs of the following four state-only programs: <ul style="list-style-type: none"> ○ Medically Indigent Adult Long-Term Care Program ○ Breast and Cervical Cancer Treatment Program ○ Genetically Handicapped Person's Program ○ California Children's Services Program <p>Funds that pass through the HCSF are to be paid in the following order:</p> <ul style="list-style-type: none"> • Meeting the baseline of the DPHs. • Federalizing the four state-only programs, and • Providing stabilization funding. <p>The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH, which will be handled as follows:</p> <ul style="list-style-type: none"> • For DPHs that have been determined to be overpaid, the Department will recoup any overpayments. • For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process. <p>The new BTR effective November 1, 2010, makes several changes to the SNCP funding. SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received. AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine (1) the federal disproportionate share hospital allotment for DPHs (2) SNCP Uncompensated Care payments, (3) DSRIP payment to DPHs. SNCP funding for the DSRIP, Designated State Health Programs (DSHP), the Low Income Health Program—Medicaid Coverage Expansion (LIHP-MCE) and the Low Income Health Program-Health Care Coverage Initiative (LIHP-HCCI) are included in separate assumptions.</p>

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

W 2 (PC-74) X X MH/UCD & BTR—DSH Payments

Effective for dates of services on or after July 1, 2005, based on SPA 05-022, approved in May 2006, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by Disproportionate Share Hospitals (DSH). Non-emergency services for unqualified aliens are eligible for DSH program funding.

DPHs claim reimbursement from the DSH allotment for up to 100% of their uncompensated care costs based on CPEs. These CPEs constitute the non-federal share of payments. Under this new methodology, each DPH certifies its Medi-Cal Managed Care and psychiatric inpatient and outpatient shortfall and its uninsured costs to the Department. The Department submits claims for federal reimbursement based on the DPHs' CPEs. The federal reimbursement that is claimed based on the CPEs is drawn from the Federal Trust Fund and passes through the Demonstration DSH Fund, Item 4260-601-7502.

DPHs also may claim up to 175 percent of uncompensated care costs. (Two University of California hospitals are not eligible for 175% reimbursement.) Intergovernmental transfers (IGTs) from the government entity with which the DPH is affiliated constitute the non-federal share of these payments. These IGTs are deposited into the MIPA Fund, Item 4260-606-0834 and are used to claim federal reimbursement. The federal reimbursement that is claimed based on the IGTs is drawn from the Federal Trust Fund.

Non-Designated Public Hospitals (NDPHs) will claim reimbursement from the DSH allotment for up to 100% of their uncompensated Medi-Cal and uninsured costs using GF as the non-federal share of payments. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

Based on SPA 05-022, private hospitals on the final DSH list receive a total funds payment of \$160.00 in annual DSH payments. The total payment of \$160.00 is comprised of 50% FFP payments from the federal DSH allotment and 50% GF. CMS required that some portion, no matter how small, of the annual DSH allotment go to the private hospitals. They indicated that the amount designated to private hospitals could be as little as \$1.00 per hospital. Since there were approximately 160 private hospitals eligible for DSH payments, it was agreed that \$160.00 would be specified in the SPA. This dollar amount was also agreed to by the DSH Task Force. The requirements of sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in this paragraph.

Each DPH's interim Disproportionate Share Hospital (DSH) payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year.

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

The reconciliation process may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DSH payments that the DPHs have received and the DSH payments determined in the reconciliation process.

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

W 3 (PC-76) X X MH/UCD & BTR—Private Hospital DSH Replacement

Effective for dates of service on or after July 1, 2005, private hospitals receive DSH replacement payments, the non-federal share of which is funded by the GF. The DSH replacement payments, along with \$160.00 of the DSH payments (see assumption for Hospital Financing DSH Payments), will satisfy the payment obligations with respect to those hospitals under the Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment.

SB 335 (**Chapter 286, Statutes of 2011**) reduces Medi-Cal DSH replacement payments to private hospitals by \$75 million GF in FY 2011-12, and \$10.5 million GF in FY 2012-13, **and \$5.25 million GF in FY 2013-14.**

W 4 (PC-79) X X MH/UCD & BTR—Private Hospital Supplemental Payment

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118.4 million annually from the GF to the Private Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. **SB 335 (Chapter 286, Statutes of 2011) reduces this annual appropriation by \$17.5 million in FY 2012-13 and \$8.75 million in FY 2013-14.** This funding replaces the aggregate amount the private hospitals received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT)), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONSApplicable F/Y
C/Y B/YW 5 (PC-94) X X MH/UCD & BTR—NDPH Supplemental Payment

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Non-Designated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually from the GF to the Non-Designated Public Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the NDPHs received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/VGT) program.

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) authorized NDPH payment methodology changes and eliminated this supplemental payment program.

W 6 (PC-82) X X MH/UCD & BTR—DPH and NDPH Physician and Non-Physician Costs

Effective for dates of service on or after July 1, 2005 reimbursement based on CPEs will be available to each DPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. SPA 05-023 that authorizes federal funding for this reimbursement was approved by CMS in December 2007. CMS approved the "Physician and Non-Physician Practitioner Time Study Implementation Plan" on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) requires the Department to change the NDPH payment methodology to a CPE methodology. The Department submitted a SPA to CMS allowing CPE-based reimbursement to be available to each NDPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. The SPA is expected to be approved in FY 2012-13 and retroactive to July 1, 2012.

W 7 (PC-95) X MH/UCD—Distressed Hospital Fund

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, "distressed hospitals" receive supplemental payments from the Distressed Hospital Fund, Item 4260-601-8033. SB

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

1100 requires the transfer of 20 percent per year over five years of the balance of the prior supplemental funds, including the ESSP Fund (SB 1255/VGT), (Item 4260-601-0693), the Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0550), the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0549), and the Small and Rural Hospital Supplemental Payments Fund (Item 4260-601-0688), to the Distressed Hospital Fund. Contract hospitals that meet the following requirements, as determined by ~~CMAC~~ **the Department**, are eligible for distressed funds:

- The hospital serves a substantial volume of Medi-Cal patients.
- The hospital is a critical component of the Medi-Cal program's health care delivery system.
- The hospital is facing a significant financial hardship.

~~The Distressed Hospital Fund ended on October 31, 2010 with the expiration of the MH/UCD waiver. Under the BTR, no separate funding is allocated to this fund. The final payment from the above four prior supplemental funds will be made in FY2011-12 depleting any remaining accumulated interest and fund balance.~~

On October 31, 2010, funding for the Distressed Hospital Fund ended with the expiration of the MH/UCD waiver and no separate funding is allocated under the BTR. Any residual balances from the above four prior supplemental funds are expected to be paid from the Distressed Hospital Fund in FY 2012-13.

The stabilization funding amounts to the Distressed Hospital Fund will be determined following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim DSH payments, and interim SNCP payments for each FY under the MH/UCD and budgeted in the Stabilization Funding policy change.

W 8 (PC-96) X X MH/UCD& BTR—MIA LTC Program— Safety Net Care Pool

Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded Medically Indigent Adult Long-Term Care program.

W 9 (PC-97) X X MH/UCD& BTR—BCCTP – Safety Net Care Pool

Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

W 10 (PC-87) X X MH/UCD& BTR—CCS AND GHPP – Safety Net Care Pool

Effective for dates of service on or after September 1, 2005, based on SB 1100, the Department may claim federal reimbursement for the CCS Program and Genetically Handicapped Persons Program (GHPP) from the SNCP established by the MH/UCD and the BTR. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

W 11 (PC-84) X X MH/UCD& BTR—DPH Interim and Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the STCs of the MH/UCD, each DPH's 2005-06 interim per diem rate is comprised of 100 percent federal funds, based on the reconciliation of each inpatient hospital costs for Medi-Cal beneficiaries to its filed Medi-Cal 2552-96 cost report.

The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and the share of cost, third liability and Medi-Cal payments.

Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

W 12 (PC-83) X X MH/UCD—Stabilization Funding

Effective for dates of service on or after July 1, 2005 through October 31, 2010, a portion of the total stabilization funding, comprised of FFP and GF, as specified in Section 14166.20 of the W&I code, will be determined as follows:

- Non-Designated public hospitals (NDPHs) will receive total funds payments equal to the difference between the sum of \$0.544 million and 0.64% of the total stabilization funding and the aggregate payment increase in the fiscal year, compared with their aggregate baseline.

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

- Private hospitals will receive total funds payments equal to the difference between the aggregate payment increase in the fiscal year, compared with their aggregate baseline, and the sum of \$42.228 million and an additional amount based on the formulas specified in W&I Code 14166.20.
- Distressed hospitals will receive total funds payments equal to the lesser of \$23.5 million or 10% of the total stabilization funding with a minimum of \$15.3 million.
- DPHs will receive GF payments to the extent that the state-funded programs' CPEs are used for FFP from the SNCP and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, private hospitals, and distressed hospitals.

~~Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Stabilization funding is also available to DPHs through the SNCP.~~

~~The stabilization funding amounts to NDPHs, private hospitals, and distressed hospitals will be calculated following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim DSH payments, and interim SNCP payments. CMAC determines the actual stabilization payments for a portion of the total stabilization amount due to NDPHs and private hospitals and all of the distressed hospital stabilization amount. The Department distributes these payments.~~

~~Stabilization funding ended on October 31, 2010 with the expiration of the MH/UCD waiver. The final reconciliations for FY 2005-06 is expected to be complete in FY 2011-12. The remaining reconciliations for MH/UCD FYs are expected to be complete in FY 2012-13 and FY 2013-14.~~

Final reconciliations for the MH/UCD stabilization funding will begin in FY 2012-13.

W 13 (PC-92) X X MH/UCD—Health Care Coverage Initiative

An amount of \$180 million in federal funds is available each year in Demonstration Years 3-5 to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provided the statutory framework for the Health Care Coverage Initiative (CI) and directed the Department to issue a Request for Applications to enable a county, a city and county, a consortium of more than one county, or a health authority to apply for an allocation of this federal funding. A total of ten programs have been selected to participate in the CI program.

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The federal funds available will reimburse the CI counties an amount equal to the applicable FMAP of their CPEs for health care services provided to eligible low-income, uninsured persons. The CI counties will submit their CPEs to the Department for verification and the Department will submit the claim for FFP that will reimburse the CI counties. No GF will be expended for this program.

In FY 2008-09, the Department began reimbursement and interim quarterly payments to the CI counties. The final reconciliation and settlement process may result in payment and recovery in future years.

This initiative ended on October 31, 2010, with the expiration of the MH/UCD. Under the BTR, the CI becomes part of the Low Income Health Program; see the Low Income Health Program assumption.

W 14 (PC-98) X X

MH/UCD & BTR—DPH Interim Rate

Effective July 1, 2005, based on SPA 05-021, DPHs no longer received SPCP negotiated per diem rates (50% GF/50% FFP.) DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. The interim per diem rates are funded using the hospitals' CPEs to match federal funds. The interim per diem rates consist of 100% federal funds; however, the Medi-Cal inpatient base estimate assumes costs are 50% GF/50% FFP. Therefore, an adjustment is necessary to shift the funding from 50% GF/50% FFP to 100% FFP.

W 15 (PC-89) X X

MH/UCD & BTR—DPH Interim Rate Growth

Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on the reported hospitals' Medi-Cal costs trended forward annually. The trend used is to reflect increased costs and is expected to be different from the former CMAC negotiated rate trend for some DPHs. The interim per diem rate consists of 100% FFP.

W 16 (OA-6) X X

MH/UCD—Health Care Coverage Initiative – Administrative Costs

FFP is available for costs incurred on or after March 29, 2007 through October 31, 2010, that are associated with the start-up, implementation and closeout administration of approved CI programs. The federal funds will reimburse the CI counties an amount equal to 50% of their CPEs for administrative costs. The administrative activities for which FFP is being requested were submitted to CMS on December 22, 2006, and approved in October 2007.

The required administrative cost claiming protocol was approved by CMS in October 2008 for prospective costs after the implementation of the time study. The Department implemented the time study in February 2009 for prospective costs and began reimbursement to the CI counties

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

in FY 2009-10. The Department received CMS approval in August 2010 for the cost claiming methodologies for the administrative costs for the period prior to the implementation of the time study, along with the start-up and close-out costs.

Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program. See assumption BTR-Low Income Health Program – Administrative Costs for more information.

W 17 (OA-30) X X MMA –DSH Annual Independent Audit

MMA requires an annual independent certified audit that primarily certifies:

- That DSH (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA.
- That hospitals' DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients.

CMS released the final regulation and criteria for the annual independent certified audit. Each year's annual report is due to CMS by December 31.

W 18 (PC-74) X X MH/UCD & BTR—ARRA – DSH Allotment and DSH Replacement
 (PC-76) Payments

California's annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.

The remaining DSH ARRA payments cannot be paid to the hospitals until the entire original DSH allotment is paid out per federal rules, therefore the Department expects to continue to pay DSH ARRA payments in FY 2011-12 and FY 2012-13.

W 19 (PC-99) X X MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

ARRA

ARRA temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The annual SNCP federal funds allotment increased accordingly. This increase in federal funds was claimed by the State through the Safety Net Care Pool via certified public expenditures. Effective November 1, 2010, under the BTR, this federal flexibility funding is no longer applicable.

Interim claims were completed in FY 2010-11. The Department will conduct the final reconciliation for ~~Demonstration Year 4 in FY 2011-12 and Demonstration Year 5 in FY 2012-13.~~

W 20 (PC-103) X ✕ MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool

The MH/UCD made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in FY 2009-10, FY 2010-11, and FY 2011-12 to claim federal funds via certified public expenditures. The final reconciliation is expected to begin in FY 2012-13.

W 21 (PC-75) X X BTR—Delivery System Reform Incentive Pool
(PC-88)

The BTR was approved by CMS effective November 1, 2010. Based on the STCs of the demonstration, the SNCP includes a Delivery System Reform Incentive Pool (DSRIP). The DSRIP is established to support California public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Funding is available in ~~four~~ **five** areas:

1. Infrastructure development
2. Innovation and redesign
3. Population-focused improvement
4. Urgent improvement in care
5. **HIV Transition Projects**

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payment to DPHs.

On June 28, 2012, CMS approved an amendment to the BTR Demonstration that authorizes HIV Transition projects to be included as a category for which DSRIP funding is available. DPHs that elect to implement DSRIP approved HIV Transition projects will

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

receive incentive payments under the SNCP upon achievement of project milestones. These projects will be effective from July 1, 2012 through December 31, 2013.

Intergovernmental transfers (IGTs) will be used as the non-federal share to claim the federal funding.

W 22 (PC-73) X X
 (PC-78)

BTR—Low Income Health Program

The BTR was approved by CMS effective November 1, 2010. The BTR modifies the existing HCCI to expand health care coverage to low income adults through the Low Income Health Program (LIHP). AB 342 (Chapter 723, Statutes of 2010) and AB 1066 (Chapter 86, Statutes of 2011) authorize the local LIHPs to provide health care services to eligible individuals.

LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). These are county-based elective programs, which will terminate on December 31, 2013, when these individuals will become eligible for Medi-Cal or the Health Benefits Exchange, as appropriate under Health Care Reform.

The counties will use certified public expenditures or capitation rates through the use of intergovernmental transfers to obtain federal funding for the LIHP. If counties that participate in the HCCI under the MH/UCD elect not to participate in the HCCI component of the LIHP, they must continue to provide health care services for existing enrollees and receive federal funding for these services.

- a. MCE will cover individuals who have family incomes at or below 133% FPL. The MCE program is not subject to a federal funding cap.
- b. HCCI will cover individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a cap of \$180 million for the first three demonstration years and \$90 million for the last year ending December 31, 2013. **This cap may vary annually; see the BTR-Health Care Coverage Initiative Rollover Funds assumption.**

W 23 (PC-93) X X

BTR—SNCP Designated State Health Programs

The BTR was approved by CMS effective November 1, 2010. Under the new demonstration, the State may claim up to \$400 million federal funds for certain state-only programs. This claiming has first priority on the SNCP funds.

CPEs from the following programs may be used to draw the federal funds:

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

- State Only Medical Programs
 - California Children's Services (CCS)*
 - Genetically Handicapped Persons Program (GHPP)*
 - Medically Indigent Adult Long Term Care (MIA-LTC)*
 - Breast & Cervical Cancer Treatment Program (BCCTP)*
 - AIDS Drug Assistance Program (ADAP)
 - Expanded Access to Primary Care (EAPC)
 - County Mental Health Services Program
 - Department of Developmental Services (DDS)
 - Every Woman Counts (EWC)
 - Prostate Cancer Treatment Program (PCTP)
 - County Medical Services Program (CMSP); effective November 1, 2010 to December 31, 2011.
- Workforce Development Programs
 - Office of Statewide Health Planning and Development (OSHDP)
 - Song-Brown Healthcare Workforce Training
 - Health Professions Education Foundation Loan Repayment
 - Health Professions Education Foundation Mental Health Loan Assumption Program
 - University of California
 - California State University
 - California Community Colleges
- Miscellaneous programs.

*Separate assumptions address the federal funds for these programs

W 24 (OA-4)	X	X	<u>BTR—Low Income Health Program – Administrative Costs</u> Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the LIHP. These costs will involve both MCE and the HCCI. FFP is available for costs incurred on or after November 1, 2010, through December 31, 2013, that are associated with the start-up, implementation and closeout administration for the LIHP. The federal funding will reimburse the programs an amount equal to 50% of their certified public expenditures for administrative costs.
W 25 (PC-86)	X	X	<u>BTR—Low Income Health Program – Inpatient Hospital Services for Inmates</u> AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department to claim federal funding for inpatient hospital services for certain State inmates in the California Department of Corrections and Rehabilitation (CDCR) correctional facilities who are enrolled under the LIHP. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those determined eligible by the Department for the LIHP program operated by the counties. The CPEs incurred by the CDCR for

1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

inpatient hospital services provided to those inmates eligible for the LIHP will be certified by CDCR. The county LIHP in which the eligible inmate is enrolled will attest to the CDCR CPEs for federal reimbursement. The Department budgets the FFP based on the counties' attestation of the CDCR CPEs.

W 26 (PC-NA) X X MH/UCD –South LA Preservation Fund

This assumption has been moved to the "Time Limited/No Longer Applicable" section.

W 27 (PC-106) X Hospital Stabilization

~~The Department is proposing legislation~~ **AB 1467 (Chapter 23, Statutes of 2012) provided the authority** to redirect private and NDPH stabilization funding that has not yet been paid. A portion of the GF savings achieved from this legislation will be used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.

W 28 (PC-85) X X NDPH Payments Changes
 (PC-91)
 (PC-102)
 (PC-104)
 (PC-105)

Prior to FY 2012-13, NDPHs received either SPCP negotiated per diem rates for contract facilities or cost-reimbursement for non-contract facilities with 50% FFP and 50% GF for Medi-Cal hospital inpatient services. ~~The Department has proposed to~~ **AB 1467 (Chapter 23, Statutes of 2012) provides the authority to:**

- Replace the current reimbursement with CPEs based reimbursement,
- Eliminate NDPH SB 1100 and AB 113 IGT supplemental payments, and
- Request federal approval to increase Safety Net Care Pool (SNCP) and DSRIP funding available for NDPHs.

W 29 (PC-81) X X BTR-Health Care Coverage Initiative Rollover Funds
 (PC-100)
 (PC-107)

HCCI, one component of BTR, covers individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a **an annual** cap of \$360 million total computable annually ~~each full Demonstration Year (DY)~~. The Department has requested federal approval to reallocate the unspent HCCI money to the SNCP uncompensated care component. The reallocated ~~fund~~ **funding** to SNCP will be shared 50/50 between DPHs and the State. **As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves \$400 million in annual General Fund savings.**

Managed Care

Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months (~~December 31, 2010~~) and plans' self-reported utilization and encounters by category of service (i.e., Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Family/Adult, and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment.

Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.

A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.

The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult/Family and Disabled Medi-Cal Only capitation rates.

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates are risk adjusted in the Family/Adult and Aged /Disabled/Medi-Cal Only Categories of Aid (COAs).

Risk Adjustment and County Averaging is prepared with plan specific pharmacy data (with NDC Codes) gathered for Managed Care and FFS enrollment data for the most recent 12 month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for 6 of the 12 months (not consecutively), then the beneficiary is counted in the plan's risk scoring calculation.

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2011-12 ~~2012-13~~ rates, ~~25~~ **35%** of this county specific rate was taken and multiplied by each plan's respective risk score and ~~75~~ **65%** of each plan's plan specific rate was retained and added to the ~~25~~ **35%** risk adjusted rate to establish a risk adjusted plan specific rate. For FY ~~2012-13~~ **2013-14** rates, the percentage of county specific rates used in the risk adjustment will increase from ~~25~~ **35%** to **35 40% with an additional quality factor of 5%**. ~~This percentage blend was chosen in order to prevent rate shock and allow the managed care plans to adjust their operations and demonstrates the Department's commitment towards using a greater percentage of the risk adjusted county average rates.~~

Managed Care

For County Organized Health Systems, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and GMC models.

Fee-for-Service Expenditures for Managed Care Beneficiaries

~~Managed care capitation payments totaled \$7.4 billion in calendar year 2009, and FFS "carve-outs" and "wrap-around" payments totaled an additional \$1.8 billion for managed care enrollees. Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.~~

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC/RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

For further information, see policy change FFS Costs for Managed Care Enrollees.

2011-12 and 2012-13 Rates 2012-13 and 2013-14 Rates

~~Overall, the rates represent a 1.4% increase in FY 2011-12 over the previous rates (based on a fiscal year comparison), which includes the impact of AB 97 10% provider rate reductions. Rates for FY 2012-13 have not yet been determined; however, a placeholder of 3.61% will be included at this time.~~ **fiscal year rates (based on a fiscal year comparison). FY 2013-14 rates have not been determined; however, a placeholder will be included based on historical rate increases, taking into consideration statutory changes, case mix changes, and health care inflation trends.**

MANAGED CARE: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

M 0.1 (PC-114)	X		<u>Retroactive Managed Care Rate Adjustments for FY 2011-12</u> CMS did not approve managed care rate adjustments for FY 2011-12 in time to be paid in FY 2011-12. These adjustments will be paid in FY 2012-13. The Department will develop and CMS will approve future fiscal year managed care rate adjustments in time so that they may be paid in the same fiscal year.
M 0.2 (PC-212)		X	<u>Enrollment Stabilization Program</u> The Department is proposing legislation to stabilize managed care enrollment. Managed care enrollees in Two-Plan and Geographic Managed Care counties would be able to switch plans once a year rather than every month. New beneficiaries will have a 90-day period from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 60-day period to change plans. Notices and packets will be mailed to beneficiaries to inform them of changes in the enrollment policy.
M 0.3 (PC-207) (PC-208) (PC-209)	X	X	<u>Extend Gross Premium Tax – Increase Capitation Rates</u> ABX1 21 (Chapter 11, Statutes of 2011) extended the gross premium tax through FY 2011-12. The Department is proposing legislation to eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. Managed Care plans affected by this new proposed legislation are: <ul style="list-style-type: none"> • Two Plan Model • County Organization Health Systems • Geographic Managed Care • AIDS Healthcare Centers • SCAN
M 0.4 (PC-213)		X	<u>Managed Care Efficiencies</u> The Department continues to seek efficiencies in the provision of services in the Medi-Cal program in order to reduce costs and improve outcomes. Instituting efficiency adjustments in the managed care rate development provides the appropriate financial incentives to health plans to seek efficiencies and avoid unnecessary costs.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-108)	X	X	<u>Two-Plan Model</u>
<p>Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed or designated managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). Currently, fourteen counties are fully operational under the Two-Plan Model.</p> <p>FY 2011-12 and FY 2012-13 capitation rates include the annual rate redeterminations. <u>Capitation rates include the annual rate redeterminations.</u></p>				
M 2	(PC-109) (PC-130)	X	X	<u>County Organized Health Systems</u>
<p>Six County Organized Health Systems (COHSs) are operational in fourteen counties. Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries. PHC is negotiating with the Department to remove undocumented beneficiaries from their contract.</p> <p>Health plans and counties currently operating under the COHS model:</p> <p>CalOPTIMA Orange County</p> <p>Santa Barbara San Luis Obispo Regional Health Authority (SBSLORHA); dba: Cen Cal Health Santa Barbara County San Luis Obispo County</p> <p>Health Plan of San Mateo (HPSM) San Mateo County</p> <p>Partnership Health Plan of California (PHC) Solano County Napa County Yolo County Sonoma County Marin County Mendocino County</p> <p>Central California Alliance for Health (CCAH) Santa Cruz County Monterey County Merced County</p>				

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Gold Coast Health Plan
 Ventura County

~~FY 2011-12 and FY 2012-13 capitation rates include the annual rate redeterminations.~~ **Capitation rates include the annual rate redeterminations.**

M 3 (PC-110) X X Geographic Managed Care

Sacramento: Geographic Managed Care (GMC), as authorized by AB 336 (Chapter 95, Statutes of 1991), was implemented in Sacramento County as of April 1994. The contractors are: Health Net Community Solutions, Inc., Anthem Blue Cross Partnership Plan, KP Cal, LLC, and Molina Healthcare of California Partner Plan, Inc.

San Diego: GMC, as authorized by SB 2139 (Chapter 717, Statutes of 1996), was implemented in San Diego County as of August 1998. Contractors are: Health Net Community Solutions, Inc., KP Cal, LLC, Molina Healthcare of California Partnership Plan, Inc., Care 1st Partnership Plan, LLC, and Community Health Group Partnership Plan.

~~FY 2011-12 and FY 2012-13 capitation rates include the annual rate redeterminations.~~ **Capitation rates include the annual rate redeterminations.**

M 4 (PC-119) X X AIDS Healthcare Centers

Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.

All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2002 are included in the plan's contracted scope of services except for new drugs which do not fit into one of the current therapeutic classes and for which the Department does not have sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan. New rates developed effective January 1, 2011, pending CMS approval, include all drugs used to treat HIV/AIDS approved by the FDA prior to January 1, 2007.

Savings Sharing/Incentive Distributions: Prior obligations exist for AIDS Healthcare Centers. These are obligations that are owed to the contractor for cost savings created when actual costs are less than FFS equivalent costs. The process of making final determinations of the amount of savings sharing can take up to one year. The Department has determined there will not be a savings sharing for calendar year 2009. Because of the long period of time needed to make the final determinations, savings sharing has not been determined for calendar year 2010 and beyond.

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

On January 1, 2012, the Department entered into a new five year contract with AHF. **On August 2, 2012, AHF received full-risk licensure. Based upon this change in status, the Department will develop a new rate. The rate will not be effective until a new contract is signed.**

M 5 (PC-122) X

Family Mosaic Capitated Case Management

Family Mosaic Project (FMP): Located in San Francisco, this program case manages emotionally disturbed children and adolescents at risk for out of home placement. Enrollment began in June 1993. FMP provides, coordinates, and oversees mental health treatment for children and youth with severe emotional and behavioral problems, targeting children who are at high risk for out-of-home placement or incarceration. FMP uses the capitation payments to provide the required services and also purchase and monitor other services from a network of private providers and community-based organizations in order to keep families together.

The Family Mosaic Project contract with the Department is ~~expected to be~~ effective January 1, 2008 through December 31, ~~2013~~ **2012**.

M 6 (PC-123)

X

Annual Redetermination of Capitation Rates

Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends. **A placeholder is included in the November estimate until rates are finalized.**

M 7 (PC-112) X

X

Managed Care Rate Range Intergovernmental Transfers

Counties will transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds will be used for the nonfederal share of capitation rate increases. The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

The following counties' IGT will continue on an ongoing basis:

<u>COHS</u>	<u>Effective Date of IGT</u>
San Mateo	July 1, 2005
Santa Barbara	July 1, 2009
Santa Cruz	July 1, 2009
Solano	July 1, 2009

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Monterey	July 1, 2009
Sonoma	October 1, 2009
Merced	October 1, 2009
Orange	July 1, 2010
Yolo	July 1, 2010
Marin	July 1, 2011

<u>Two Plan Model</u>	<u>Effective Date</u>
Los Angeles	October 1, 2006
Alameda	October 1, 2008
Contra Costa	October 1, 2008
Kern	October 1, 2008
Riverside	October 1, 2008
San Bernardino	October 1, 2008
San Francisco	October 1, 2008
San Joaquin	October 1, 2008
Santa Clara	October 1, 2008

M 8 (PC-125) X Managed Care IGT Administrative and Processing Fee

Counties may transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases. Beginning with FY 2010-11 rate range IGTs processed after July 1, 2011, and all subsequent rate range IGTs occurring after July 1, 2011, the Department will charge counties an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the cost of medical services provided under the Medi-Cal program.

AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs are subject to the fee with the exception of the IGTs related to Designated Public Hospitals (DPHs). If the IGT is replacing the CPE previously claimed in fee-for-service, no fee will be charged.

M 9 (PC-111) X Managed Care Public Hospital IGTs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage are being assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. In conjunction with this, SB 208 (Chapter 714, Statutes of 2010) allows public entities, such as Designated Public Hospitals (DPH), to transfer funds under Intergovernmental Transfers (IGT) to the Department, pending CMS approval. The funds will be used as the non-federal share of capitation rate increases. This will enable plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the FFS model, including supplemental payments, CPEs and any additional federally permissible amounts, which are available only under FFS.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
M 10	(PC-126)	X	<p><u>General Fund Reimbursements from DPHs</u></p> <p>Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. For Medi-Cal beneficiaries under the FFS program, payments to Designated Public Hospitals (DPHs) are comprised of CPEs matched with federal funds. For Medi-Cal beneficiaries under managed care, payments to DPHs are comprised of General Fund and federal funds. Therefore, as SPDs are transitioned into managed care, GF expenditures will increase for DPH services.</p> <p>Beginning in FY 2012-13, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.</p>
M 11	(PC-120)	X X	<p><u>Increase in Capitation Rates for Gross Premium Tax</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) has imposed a Gross Premium Tax on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. The provision pertaining to this tax is effective retroactively to January 1, 2009. <u>The Gross Premium Tax</u> and will sunset on June 30, 2012. <u>The Department has proposed legislation to extend the tax through June 30, 2014 .</u> Managed Care plans affected by this new legislation are:</p> <ul style="list-style-type: none"> • Two Plan Model • County Organization Health Systems • Geographic Managed Care • AIDS Healthcare Centers • SCAN
M 12	(PC-127)	X X	<p><u>Funding Adjustment of Gross Premium Tax Funds to GF</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) imposed an additional tax on the total operating revenue of Medi-Cal Managed Care Organizations (MCOs). The taxes are then placed in a special tax fund and are used to increase the capitation rates to reimburse the cost of the tax to the plans.</p> <p>Capitation rate increases due to the tax are initially paid from the General Fund. The Department then requests quarterly reimbursement of the General Fund through a funding adjustment from the Tax Fund.</p>

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
M 13	(PC-NA) (PC-NA) (PC-NA)	X X	<p><u>Extend Gross Premium Tax – Increase Capitation Rates</u></p> <p>ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through FY 2011-12. The Administration Department is proposing legislation to eliminate that would extend the Gross Premium Tax sunset date on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2014. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. Managed Care plans affected by this new proposed legislation are:</p> <ul style="list-style-type: none"> • Two Plan Model • County Organization Health Systems • Geographic Managed Care • AIDS Healthcare Centers • SCAN
M 14	(PC-128)	X X	<p><u>FFS Costs for Managed Care Enrollees</u></p> <p>Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are CCS services and anti-psychotic drugs. Additionally, the Department pays federally qualified health care centers and rural health clinics under the fee-for service system for certain costs associated with serving Medi-Cal managed care enrollees which are not fully paid by Medi-Cal managed care plans.</p>
M 15	(OA-29)	X X	<p><u>San Diego County Administrative Activities</u></p> <p>The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003.</p>
M 16	(PC-116)	X X	<p><u>Managed Care Cost Based Reimbursement Clinics (CBRC)</u></p> <p>The Department is required to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. Currently, tentative settlements are prepared by the Department after review of reconciliation requests and final settlements or recoveries are invoiced within three years after the submission of the original reconciliation reports.</p>

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Effective October 1, 2011, CBRCs that provide services to Seniors and Persons with Disabilities (SPDs) who reside in Los Angeles County and are enrolled in managed care plans will be reimbursed through managed care capitation rates.

M 17 (PC-131) X X Managed Care Default Assignment

~~The Department is proposing legislation that would require~~ **AB 1467 (Chapter 23, Statutes of 2012) requires** beneficiaries in the Family or Seniors and Persons with Disabilities (SPD) aid categories who do not choose a plan to be defaulted in a plan based on default ratios which consider health plan quality of care and cost. ~~Savings would be recognized by rewarding plans with lower costs with additional default enrollments.~~

M 18 (PC-134) X X Align Managed Care Benefit Policies

Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. ~~Currently~~ **Previously**, the COHS ~~are~~ **were** responsible for covering the cost of the retroactive period and they ~~receive~~ **received** an adjustment in their capitation rates for this cost. The Two-Plan and Geographic Managed Care health plans are not responsible to cover the costs of their enrollees during the retroactive period. Instead, these costs are paid in FFS. ~~The Administration proposes to eliminate~~ **Effective July 1, 2012, the Department eliminated** the COHS' responsibility for the retroactive period and ~~shift~~ **shifted** this cost to FFS.

M 19 (PC-198) X X Transition of Dual Eligibles-Medicare Savings

~~The Department will identify~~ **identified** demonstration projects to integrate Medicare and Medicaid services under a new 1115 Demonstration Project Waiver. The new waiver includes providing long-term care services and supports for dual eligible beneficiaries. ~~The projects will be established in up to ten counties through COHS, two-plan and GMC models.~~

The goals of the pilot projects include:

- Coordinating Medi-Cal and Medicare benefits across health care settings to improve continuity and access to acute care, long-term care, and HCBS,
- Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services, and
- Increasing the availability of and access to home and community-based alternatives.

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The Department ~~expects to identify pilot~~ **has identified demonstration** projects by April 2012 and begin pilot implementation in January 2013 **in Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara counties. Implementation will begin between March 2013 and June 2013.** The pilot will assume **demonstration assumes** shared savings between Medicare and Medicaid. A blended rate for health care costs split between Medicare and Medicaid is yet to be determined.

M 20 (PC-113) X
 (PC-135)
 (PC-192)
(PC-214)
(PC-215)
 (PC-FI)
 (OA-19)
 (OA-71)

X Transition of Dual Eligibles-Long-Term Care Savings

The Department will achieve savings from transitioning dually eligible **and Medi-Cal only** beneficiaries who receive Medi-Cal Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), **Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP)** and other Home and Community-Based Services (HCBS) from fee-for-service into managed care health plans. Notices and packets will be mailed to beneficiaries.

The administrative costs to enroll beneficiaries into the managed care health plans include:

- **Mailing Medi-Cal and Medicare information,**
- Outreach services,
- Rate setting for newly included long-term services and supports (LTSS),
- **System design and modification needs,**
- Medicare and Medi-Cal data collection, ~~and~~
- **Development of quality metrics,**
- **Performance measures for rapid cycle quality improvement and long-term** quality assurance, and
- Monitoring by an External Quality Review Organization (EQRO).

Other administrative costs include the Health Insurance Counseling and Advocacy Program (HICAP) which provides one-on-one Medicare counseling services.

M 21 (PC-132) X

X Managed Care Expansion to Rural Counties

Managed care is currently in 30 counties. ~~The Department is proposing to expand~~ **AB 1467 (Chapter 23, Statutes of 2012) expands** managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
M 22	(PC-NA)	X	X	<u>Coverage for Former Agnews Residents</u> This assumption has been moved to the "Fully Incorporated into Base/Ongoing" section.
M 23	(PC-NA)	X		<u>Court-Ordered Managed Care Rate Adjustments</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.
M 24	(PC-NA)	X	X	<u>Mandatory SPD Enrollment into Managed Care</u> This assumption has been moved to the "Fully Incorporated into Base/Ongoing" section.
M 27	(PC-NA)	X		<u>Rate Increases due to SB 90 IGTs</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.
M 28	(PC-133) (Reworded)	X	X	<u>Potentially Preventable Admissions</u> The Department analyzed historical encounter data to identify situations where an inpatient admission was potentially preventable and quantified the level of inefficiency and/or potentially avoidable expenses present in the base data for managed care plans. Based on the analysis, the Department imposed an adjustment to Medi-Cal Managed Care rates to account for potentially preventable admissions into hospital inpatient facilities.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personnel activities. Costs are limited to the 90th percentile of each facility's peer group.
- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

Rate Years 2011-12 and 2012-13

~~Pursuant to AB 97 (Chapter 3, Statutes of 2011), provider payments will be reduced by 10% for FFS claims, retroactive to June 1, 2011 and the actuarial equivalent of 10% for managed care claims, retroactive to July 1, 2011.~~

PROVIDER RATES

~~Under ABX1 19 (Chapter 4, Statutes of 2011), the Department extended the provisions of AB 1629 to July 31, 2013. Also, facilities will receive a rate increase of approximately 0.426% for rate year 2011-12 and a rate increase of 1.973% for rate year 2012-13 rate-year, for a total increase of 2.4%.~~

~~Also, the 10% provider payment reduction for AB 1629 facilities will end on August 1, 2012, and the Department will provide a one-time supplemental payment in rate year 2012-13 that will be equivalent to the 10% reduction applied from June 1, 2011 to July 31, 2012. In addition, in rate year 2012-13, the Department will hold harmless any facility from rates that are less than the rates on file as of May 31, 2011.~~

Quality and Accountability Supplemental Payment System

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) System for SNFs by August 1, 2010. The QASP system will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents.

Rate Years 2011-12 and 2012-13

~~ABX1 19 (Chapter 4, Statutes of 2011) requires the Department to delay implementation of the QASP for one year, and establish FY 2011-12 as the base year for data collection. In rate year 2012-13, the Department will set aside 1% of the AB 1629 facilities reimbursement rate, which will be used to make supplemental payments under the QASP to reward facilities.~~

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The ~~current~~ reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

PROVIDER RATES

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location and bed size. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Providers of services to developmentally disabled clients have rates set at the 65th percentile of their respective peer groups.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

Rate Years 2011-12 and 2012-13 Rates

Pursuant to AB 97 (Chapter 3, Statutes of 2011), provider payments will be reduced by 10% for FFS claims, retroactive to June 1, 2011 and the actuarial equivalent of 10% for managed care claims, retroactive to July 1, 2011.

Pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will reduce payments for Freestanding Pediatric Subacute Care Facilities by 5.75% (rather than 10%) based on the 2008-09 rate-year rates. Effective January 1, 2012, a QAF will be assessed on Freestanding Pediatric Subacute Care Facilities.

PROVIDER RATES: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

PR 1

NF-B Rate Changes and Quality Assurance (QA) Fee

AB 1629 (Chapter 875, Statutes of 2004) required the Department to change the rate methodology for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding adult subacute facilities, excluding pediatric subacute services and rural swing bed days), to provide an annual cost-of-living adjustment (COLA) and to collect a QA fee from these facilities. **Effective January 1, 2012, ABX1 19 includes Freestanding Pediatric Subacute facilities within the QA fee provider population.** The rate methodology and QA fee provisions sunset on July 31, 2013. **AB 1489 (Chapter 631, Statutes of 2012)** The Department has proposed to permanently extend the QA fee, **until July 31, 2015.**

(PC-138) X X Rate Changes due to Rate Methodology

ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 rate year, and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year, ~~and a rate adjustment of 1.973% will be provided in the 2012-13 rate year.~~ **AB 1489 (Chapter 631, Statutes of 2012) provides a rate freeze for the 2012-13 rate year and a 3% rate increase for the 2013-14 rate year.**

(PC-141) X X Rate Adjustments due to the QA Fee

Assessment of the QA fee is based on revenues from Medi-Cal, Medicare and private pay sources. Effective October 1, 2011, the QA fee limit ~~will increase~~ **increased** from 5.5% to 6%.

QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. L&C fees shift from year to year, which impacts the amount of QA fee the Department can collect. The State uses a portion of the QA fee to draw down FFP and to fund rate increases. Rate increases due to the QA fee are expected to be cost neutral to the General Fund.

SB 853 (Chapter 717, Statutes of 2010) requires the Department to expand the amount of revenues upon which the QA fee is assessed by including revenue from Multi-Level Retirement Communities (MLRCs) and revising the QA Fee trending methodology. This will result in rate increases to the facilities. SB 853 established an allowable overall rate increase of up to 2.4% for rate year 2011-12. Under SB 853, the QAF fee sunsets as of July 31, 2012.

ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 **and 2012-13** rate year **years**, and

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year, and a rate adjustment of 1.973% will be provided in the 2012-13 rate year. ABX1 19 also extended the QA fees sunset date by one year, to August 1, 2013. **AB 1489 (Chapter 631, Statutes of 2012) implements a rate freeze for the 2012-13 rate year and extends the QA fees sunset date to July 31, 2015.**

(PC-145) X X Quality and Accountability Payments Program

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payments program for freestanding nursing facilities (NF-Bs), with the first phase beginning in rate year 2010-11. **Quality payments will be delayed a year by AB 1489 (Chapter 631, Statutes of 2012).** Payments made under the program will begin in rate year 2012-13 **2013-14** as supplemental to the rates and will be paid through a special fund. The special fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, 4% **one-third** of the AB 1629 facilities reimbursement rate **increase** for rate year 2012-13 **2013-14 (up to a maximum of 1 % of the overall rate)**, and the savings achieved from setting the professional liability insurance cost category at the 75th percentile. **Per AB 1489 (Chapter 631, Statutes of 2012), the professional liability insurance cost category will still be set at the 75th percentile in 2012-13, but saving will be retained by the state.**

(PC-138) X X AB 1629 Add-Ons to the Rates

CMS mandated that skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. ~~The~~ **An add-on to the rate increase was** effective August 1, 2011, and retroactive to October 1, 2010.

Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional costs was effective August 1, 2011, and retroactive to October 2009.

Effective January 2011, the California Department of Public Health (CDPH) mandated SNFs to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to January 2011.

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Effective April 2012, CDPH requires providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012.

Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from the Version 4010/4010A to Version 5010 transaction standards. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012 and retroactive to January 2012.

Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation \$0.02 add-on reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year.

The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. A \$0.11 add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.

Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act \$0.01 add-on reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.

PR 2 (PC-153) X X 10% Payment Reduction

AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a payment reduction of up to 10% to specified providers in FFS, effective June 1, 2011. The actuarial equivalent of that amount to specified managed care providers was implemented July 1, 2011.

On October 27, 2011, the Department received federal approval to reduce provider payments up to 10%.

The Department submitted a State Plan Amendment on June 13, 2012, requesting CMS approval to exempt Pediatric Day Health Care providers from the 10 percent payment reduction, effective April 1, 2012.

PR 3 (PC-143) X X Annual MEI Increase for FQHCs and RHCs

The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) included in the 2000 Benefits Improvement and Protection Act

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1st of each year.

PR 4

LTC Rate Adjustments and QA Fees

(PC-140) X X Rate Adjustment

Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of an annual rate study.

The following facilities are included in this assumption:

- Intermediate Care Facilities/Developmentally Disabled (ICF-DD)
- ICF/DD-Habilitative
- ICF/DD-Nursing
- Freestanding Nursing Facilities – Level A (NF-A)
- Distinct Part Nursing Facilities (DP/NF) – Level B
- DP/NF Subacute
- Pediatric Subacute Care
- Rural Swing Beds
- ~~Adult Day Health Care/Community-Based Adult Services~~

(PC-150) X X Rate Freeze

ABX4 5 (Chapter 5, Statutes of 2009), froze rates for all LTC facilities for rate year 2009-10 and every year thereafter at the 2008-09 levels.

Under *CHA v. David Maxwell-Jolly*, the Department was enjoined from freezing rates under ABX4 5 for:

- Distinct Part Nursing Facilities Level B (DP/NF-B)
- DP/NF adult
- DP pediatric subacute
- Rural swing bed providers.

The following facilities were not part of the lawsuit, and their rates continue to be frozen:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A),
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), **including Habilitative and Nursing**
- FS pediatric subacute facilities

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

AB 97 (Chapter 3, Statutes of 2011) requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97.

Currently the following long-term care providers are subject to the rate freeze:

- **Intermediate Care Facilities (Freestanding Nursing Facilities, Level A),**
- **DP/NF-B,**
- **Rural Swing Bed,**
- **Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing, and**
- **FS pediatric subacute facilities**

(PC-152) X X

10% Payment Reduction

AB 97 (Chapter 3, Statutes of 2011) also required the Department to reduce payments to long-term care facilities by up to 10% in FFS, effective June 1, 2011. The actuarial equivalent of that amount in managed care was implemented July 1, 2011. Subsequently, ABX1 19 (Chapter 4, Statutes of 2011) requires the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% of rate year 2008-09 rates.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97. DP/NF adult subacute, DP and FS pediatric subacute, rural swing bed, NF-A, and ICF/DD (including Habilitative and Nursing) facilities were not part of the lawsuit.

The following long-term care providers are not subject to the 10% payment reduction:

- Distinct Part Adult Subacute Facilities
- Distinct Part Pediatric Subacute Facilities
- Hospice Providers
- Hospice Room and Board Providers
- **Rural Swing Bed Rate**

The following long-term care providers are subject to the 10% payment reduction:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A)
- Distinct Part Nursing Facilities, Level B

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing – The Department ~~will be submitting~~ **recently submitted** a request to CMS to modify the rate-setting methodology, which will result in reduced rates of up to 10% for some facilities.

(PC-140) X X QA Fees

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) ~~are required to pay a QA fee. Pursuant to ABX1 19 (Chapter 4, Statutes of 2011), beginning August 1, 2011, and~~ Freestanding Pediatric Subacute Care facilities ~~will be~~ **are** required to pay a QA fee. ~~Currently, the QA fee is capped at 5.5% of total gross revenues. Effective October 1, 2011, the~~ **The** federal government ~~will allow~~ **allows** states to ~~cap~~ **assess** the QA fee at 6% of total gross revenues. The fee is used to draw down FFP and fund rate increases, which are expected to be cost neutral to the GF.

(PC-140) X X Non-AB 1629 Add-Ons to the Rates

CMS mandated that freestanding and distinct part skilled nursing facilities, including Adult and Pediatric Subacute, upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. The rate increase was effective August 1, 2011, and retroactive to October 1, 2010.

Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional costs was effective August 1, 2011, and retroactive to October 2009.

- Effective January 2011, the California Department of Public Health (CDPH) mandates LTC facilities to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to January 2011.**
- Effective April 2012, CDPH requires providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012.**

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from Version 4010/4010A to Version 5010 transaction standards. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012 and retroactive to January 2012.
- Effective July 1, 2010, SB 183 (Chapter 19, Statutes of 2010), the Carbon Monoxide Poisoning Prevention Act, requires single-family dwelling units to have installed a carbon monoxide device that is designed to detect carbon monoxide and produce a distinct, audible alarm, which must be approved by the State Fire Marshal. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to July 2011. This add-on is only applicable to ICF/DD Hs and Ns.
- Adult Day Holiday mandated add-on reimburses ICF/DD facilities for adult day care or transportation service during the period between Christmas and New Years. A \$0.16 add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on from \$0.11 through \$0.17 to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation add-on from \$0.02 through \$0.06 reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year excluding ICF/DD, ICF/DD-H and ICF/DD-N.
- Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act add on from \$0.01 through \$0.04 reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.

PR 5 (PC-144) X

X

Hospice Rate Increases

Pursuant to state regulations, Medicaid hospice rates are established in accordance with 1902(a)(13), (42 USC 1396a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. New hospice rates are effective October 1st of each year.

Effective February 1, 2003, hospice room and board providers are reimbursed at 95% of the Medi-Cal per-diem rate paid to the facility with

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

which the hospice is affiliated. This change in reimbursement methodology was made to reflect the CMS allowable rate, in accordance with 42 USC 1396a(a)(13)(B) and 1902(9a)(13)(B) of the federal Social Security Act.

PR 6 (PC-NA) X X Alternative Birthing Centers

Pursuant to W & I Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase each year by the same percentage as the CMAC average acute care hospital contract rate. **Effective July 1, 2013, rates will increase each year by the same percentage as the average increase in Diagnosis Related Groups base prices.**

PR 7 (PC-149) X X Reduction to Radiology Rates

SB 853 (Chapter 717, Statutes of 2010) reduced Medi-Cal rates for radiology services to 80% of Medicare rates, effective October 1, 2010. **It is expected that the rate methodology will be implemented in January 2013 with** rate reductions ~~will be implemented, retroactive to October 1, 2010~~ **July 1, 2012 in order to protect beneficiary access to needed radiology services.**

PR 8 (PC-142) X X Air Ambulance Medical Transportation

AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 upon every conviction involving a vehicle violation, effective January 1, 2011. The bill requires the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act (EMATA) Fund.

AB 215 (Chapter 392, Statutes of 2011) removed a county's ability to retain a portion of moneys collected from the penalties to administer the EMATA and deletes the requirement that counties submit an annual report to the Department on the funds the county retained for administration costs.

After the payment of the Department's administrative costs, 20% of the fund will be allocated to the General Fund. The remaining 80% in the EMATA fund will be matched with federal funds and will be used to increase the payments and/or rates for medical emergency Medi-Cal **emergency** air medical transportation services.

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

PR 9	(PC-138) X (PC-139)	X	<p><u>10% Payment Reduction Restoration and Supplemental Payments</u></p> <p>Under ABX1 19 (Chapter 4, Statutes of 2011), the 10% payment reduction for AB 1629 facilities will end <u>ended</u> July 31, 2012. ABX1 19 requires the Department to:</p> <ul style="list-style-type: none"> • Provide a one-time supplemental payment in FY 2012-13 that is equivalent to the reduction applied from June 1, 2011 <u>May 1, 2012</u> through July 31, 2012, • Provide an allowable rate increase up to 2.4% for the 2011-12 rate year. Under ABX1 19, a rate adjustment of 0.426% was provided for the 2011-12 rate year, and a rate adjustment of 1.973% will be provided in the 2012-13 rate year. • Hold harmless in rate year 2012-13 any facility from rates that are less than the rates that were on file on May 31, 2011. <p><u>AB 1489 (Chapter 631, Statutes of 2012) freezes rates and eliminates the hold harmless for 2012-13 rate year and provides a 3% rate increase in 2013-14.</u></p>
PR 10	(PC-136) X	X	<p><u>ACA – Payments to Primary Care Physicians</u></p> <p>This assumption has been moved to “Affordable Care Act-Old Assumptions” section.</p>
PR 11	(PC-151) X	X	<p><u>Eliminate 2012-13 Rate Increase & Supp. Payment</u></p> <p><u>AB 1489 (Chapter 631, Statutes of 2012) authorizes</u> the Department is proposing legislation to:</p> <ul style="list-style-type: none"> • Redirect funding for rate increases and supplemental payments for AB 1629 facilities to the GF in 2012-13, <u>and</u> • <u>Allow for the savings associated with the Professional Liability Insurance (PLI) cost category capped at the 75th percentile to remain in the General Fund rather than being transferred to the Quality and Accountability Supplemental Payment (QASP) Fund.</u>

PROVIDER RATES: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

PR 12 (PC-146) X

Preserving Contract Hospitals

SB 90 (**Chapter 19, Statutes of 2011**) included a provision that required a reduction in amount of any QAF supplemental payment for a contract hospital that converts to non-contract status. This reduction is equal to the amount by which the hospital's overall payment for Medi-Cal services was increased during the program period by reason of it becoming a noncontract hospital.

PR 13 (PC-148) X

X

Clinical Laboratory Reimbursement Methodology

AB 1494 (Chapter 28, Statutes of 2012) allows the Department to develop a new rate methodology for clinical laboratory and laboratory services. In addition to 10% payment reductions implemented pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allows payments to be reduced by an additional 10% for dates of service on and after July 1, 2012. The 10% payment reduction pursuant to AB 1494 shall continue until the new rate methodology has been approved by CMS. The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.

SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
SP 0.1	(PC-205) (PC-206)		X	<u>Extend Hospital QAF</u>
				The current Hospital QAF program will end on December 31, 2013. The Department proposes to extend the program from January 1, 2014 through December 31, 2016.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/YSP 1 (PC-158) X X Capital Project Debt Reimbursement

SB 2665 (Chapter 1310, Statutes of 1990) and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the W&I Code.

SB 1128 (Chapter 757, Statutes of 1999) authorizes a Distinct Part (DP) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP must meet other specific hospital and project conditions specified in Section 14105.26 of the W&I Code. Two DP facilities began submitting claims and received payments in FY 2011-12.

SP 2 (PC-155) X X Hospital Outpatient Supplemental Payments

AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal share used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Interim payments are expected to be made every year in June. Interim payment adjustments are made upon receipt and review of amended claims.

The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY 2012-13. Adjustments to interim payments, or recoupment of overpaid funds, are expected during FY 2012-13. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.

SP 3 (PC-161) X X IGTs for Non-SB 1100 Hospitals

W&I Code, Section 14164, provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program. The IGT will be used as the non-federal share of cost in order to draw down FFP, which will then be distributed to the hospitals designated by the county or health care district.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
SP 4	(PC-156)	X	X	<u>FFP for Local Trauma Centers</u>
The Budget Act of 2003 provided authority for Los Angeles County and Alameda County to submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down federal funds. The combined funds will be used to reimburse specified hospitals for costs of trauma care provided to Medi-Cal beneficiaries.				
SP 5	(PC-160)	X	X	<u>Certification Payments for DP-NFs</u>
AB 430 (Chapter 171, Statutes of 2001) allows Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district.				
SP 6	(PC-162)	X	X	<u>Medi-Cal Reimbursements for Outpatient DSH</u>
SB 2563 (Chapter 976, Statutes of 1988) created a supplemental program for hospitals providing a disproportionate share of outpatient services. Eligible DSH providers are reimbursed on a quarterly basis through a Payment Action Notice (PAN) to the Fiscal Intermediary (FI). The payment represents one quarter of the total annual amount due to each eligible hospital.				
SP 7	(PC-163)	X	X	<u>Medi-Cal Reimbursements for Outpatient Small and Rural Hospitals</u>
AB 2617 (Chapter 158, Statutes of 2000) requires the Department to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). Eligible SRH providers are reimbursed on a quarterly basis through a PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.				
SP 8	(PC-157) (PC-164)	X	X	<u>Freestanding Outpatient Clinics and State Veterans' Home Supplemental Payments</u>
AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics and state veterans' homes to the current Medi-Cal outpatient supplemental program. Under this program, clinics that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, or health care district are also eligible to receive supplemental payments.				
The non-federal match is paid from public funds of the participating facilities.				

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year starting August 1, 2006. Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning July 1, 2006 pending an approved State Plan Amendment. The SPA is expected to be approved in FY 2011-12 **2012-13**.

SP 9 (PC-164) X X

State Veterans' Home Supplemental Payments

AB 959 (Chapter 162, Statutes of 2006) adds state veterans' homes to the current Medi-Cal outpatient supplemental program. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the State are eligible to receive supplemental payments. The non-federal match is paid from public funds of the participating facilities.

The SPA for state veterans' homes was approved March 3, 2011. Supplemental payments were effective retroactively beginning with the rate year starting August 1, 2006.

SP 10 (PC-61) X X

Specialty Mental Health Services Supplemental Reimbursement

ABX4 5 (Chapter 5, Statutes of 2009) creates a provision to allow an eligible public agency receiving reimbursement for specialty mental health services provided to Medi-Cal beneficiaries to also receive supplemental Medi-Cal reimbursement up to 100% of actual allowable costs.

The supplemental payment amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share of costs used to draw down FFP for the supplemental payments will be expended from the public agency and will not involve General Fund dollars.

The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. The Department ~~and CDMH~~ **is** providing additional information to CMS. Upon approval, supplemental payments will be authorized retroactive to January 2009, with payments expected to be made beginning FY 2011-12 **2012-13**.

The Supplemental Payment Program will be included in the Specialty Mental Health Services (SMHS) Waiver.

SP 11 (PC-159) X X

NDPH IGT Supplemental Payments

AB 113 (Chapter 20, Statutes of 2011) establishes a supplemental payment program for Non-Designated Public Hospitals (NDPHs). These payments are funded with Intergovernmental Transfers (IGTs) and are

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

distributed to the NDPHs based upon a formula in the statute. The State retains nine percent of the IGTs to fund administrative costs and Medi-Cal children's health programs.

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) authorized NDPH payment methodology changes and eliminated this supplemental payment program.

SP 12 (PC-154) X
(PC-203)
(Reworded)

X

Hospital QAF – Hospital Payments

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

AB 188 (Chapter 645, Statutes of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 (Chapter 19, Statutes of 2011) extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011 based on a modified amount of payments to hospitals and an increased amount for children's health care coverage.

SB 335 (Chapter 286, Statutes of 2011) extended the Hospital QAF program from July 1, 2011 through December 31, 2013. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children's health care coverage by:

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SP 13

SB 90 Hospital Inpatient Reimbursement

SB 90 (Chapter 19, Statutes of 2011), an urgency bill signed April 13, 2011, made a number of changes to the Medi-Cal program:

(PC-76) X X MH/UCD & BTR—Private Hospital DSH Replacement

This assumption has been moved to “1115 Waiver – MH/UCD & BTR: Old Assumption” section.

(PC-154) X X Hospital QAF – Hospital Payments

This assumption has been moved to “SP 12: Hospital QAF – Hospital Payments” assumption.

(PC-146) X Preserving Contract Hospitals

This assumption has been moved to the “Provider Rates: Old Assumptions” section.

(PC-NA) X X Non-Contract Hospital Rate and Payment Changes

This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.

SP 14

SB 335 Hospital Inpatient Reimbursement

SB 335 (Chapter 286, Statutes of 2011), an urgency bill, made a number of changes to the Medi-Cal program:

(PC-190) X X Hospital QAF – Children’s Health Care

This assumption has been moved to “SP 17: Hospital QAF – Children’s Health Care” assumption.

(PC-80) X X Low Income Health Program Out-Of-Network Fund

SB 335 creates the Low Income Health Program Out-of-Network Medi-Cal Expansion Emergency Care Services Fund (LIHP Fund) to pay for emergency care services to LIHP beneficiaries at out-of-network hospitals. Annually, \$20 million in IGTs from designated public hospitals and \$75 million from the Hospital Quality Assurance Revenue Fund will be paid to out-of-network hospitals.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
(PC-76)	X	X	<u>MH/UCD & BTR—Private Hospital DSH Replacement</u> This assumption has been moved to the “1115 Waiver—MH/UCD & BTR: Old Assumptions” section.
(PC-79)		X	<u>MH/UCD & BTR—Private Hospital Supplemental Payment</u> This assumption has been moved to the “1115 Waiver—MH/UCD & BTR: Old Assumptions” section.
(PC-154)	X	X	<u>Hospital QAF – Hospital Payments</u> This assumption has been moved to “SP 12: Hospital QAF – Hospital Payments” assumption.
SP 15 (PC-165)	X	X	<u>GEMT Supplemental Payment Program</u> AB 678 (Chapter 397, Statutes of 2011) provides supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers. Supplemental payments combined with other reimbursements cannot exceed 100% of the costs. Governmental entities provide the non-federal share through CPEs. Once the SPA is approved by CMS, the supplemental reimbursement program will be retroactive to January 30, 2010. <u>The SPA is expected to be approved in FY 2012-13.</u>
SP 16 (PC-203)		X	<u>Hospital QAF Program Changes</u> This assumption has been moved to “SP 17: Hospital QAF – Children’s Health Care” and “SP 12: Hospital QAF – Hospital Payments” assumptions.
SP 17 (PC-190) (PC-203)	X	X	<u>Hospital QAF – Children’s Health Care</u> SB 335 (Chapter 286, Statutes of 2011) extended the Hospital QAF program from July 1, 2011 through December 31, 2013, which will provide additional funding to hospitals and for children’s health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals. <u>AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children’s health care coverage.</u>

OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/YA 1 (PC-184) Lawsuits/Claims*Applicable F/Y
C/Y B/Ya. Attorney Fees of \$5,000 or Less

Total

\$0

Fund Balance \$50,000

\$50,000

\$50,000

b. Provider Settlements of \$75,000 or Less

1. Daughters of Charity Health System	\$8,433
2. CFHS Holdings, Inc.	\$16,945
3. Daughters of Charity Health System	\$9,510
4. Brotman Medical Center	\$2,318
5. Alameda Hospital	\$709
6. CHA Hollywood Medical Center L.P.	\$1,003
7. Good Samaritan Hospital	\$30,150
8. Providence Health System	\$19,771
9. Catholic Healthcare West	\$13,341
10. Country Oaks Partners, LLC	\$36,551
11. Alta Los Angeles Hospitals	\$27,600
12. Alta Hospitals System	\$3,764
13. Catholic Healthcare West	22,336
14. CHA Hollywood Medical Center L.P.	\$9,173
15. Daughters of Charity Health System	\$475
16. Daughters of Charity Health System	\$3,177
17. Avanti Health System, LLC	\$23,342
18. Cedars-Sinai Medical Center	\$15,555
19. Daughters of Charity Health System	\$49,719
20. CFHS Holdings, Inc.	\$13,099
21. Providence Health System-Southern California	<u>\$19,934</u>
Total	\$326,905

Fund Balance \$1,273,095

\$1,600,000

\$1,600,000

c. Beneficiary Settlements of \$2,000 or Less

Fund Balance

\$15,000

\$15,000

d. Small Claims Court Judgments of \$5,000 or Less

Fund Balance

\$200,000

\$200,000

e. Other Attorney Fees

1. Western Center on Law and Poverty	\$131,816
2. Helen Rose Griffin	\$40,700
3. California Association of Rural Health	\$35,585
4. Rosemary Carpendale	<u>\$7,653</u>
Total	\$215,754

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Yf. Other Provider Settlements / Judgments

1. Country Oaks Partners, LLC	\$79,912
2. Molina Healthcare of California	\$1,100,000
3. Cedars-Sinai Health Systems	<u>\$400,000</u>
Total	\$1,579,912

g. Other Beneficiary Settlements

Amounts may exclude interest payments.

A 2 (PC-121) X X Notices of Dispute / Administrative Appeals – Settlements

Settlement agreements for disputes between the Department and the managed care plans are estimated to be \$2,000,000 for possible settlements for each fiscal year.

A 3 (PC-NA) Minor Consent Settlement

This assumption has been moved to "Time Limited/No Longer Applicable" section.

A 4 (OA-15) X X Litigation-Related Services

The Department continues to experience significant and increasing litigation costs in defense of the Medi-Cal program. The number of open cases has increased, and the Department of Justice rates for litigating these cases have increased.

Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for the Department's consulting actuaries to comply with the requirements of the court rulings.

A 5 (PC-50) X Litigation Settlements

The Department continues to work collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks, overcharging, and overpayments. Settlements are expected to be received in FY ~~2011-12~~ **2012-13** from Seaciff Diagnostics Medical Group; ~~Mariner Health Care, Inc. and Sava Senior Care Administrative Services, LLC; Novartis; Eisai/Elan; Quest Diagnostics; Novo Nordisk; Serono; Merck; Lab Corp; CVS; Maxim; Pfizer; UCB, Inc.; Whitefield Medical Lab and Ven-A-Care of the Florida Keys (Sandoz)~~ **GlaxoSmithKline, LLC; Bioscrip; Boehringer Ingelheim Pharmaceuticals, Inc.; McKesson; A-Med Pharmacy; Dava Pharmaceuticals, Inc.; Walgreen's Pharmacy; Senior Care Action Network; Bio-Med Plus, Inc.; and KV Pharmaceuticals.**

A 6 (PC-171) X X AB 97 Injunctions

The U.S. District Court, Central District of California, issued a preliminary injunction in the following cases related to AB 97:

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

- December 28, 2011 – *California Hospital Association v. Douglas, et al.*: The Department is prohibited from implementing reductions to hospital-based nursing facilities. **On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011, that were not reimbursed prior to that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of the injunction, and the hearing is set for October 10, 2012.**
- December 28, 2011 – *Managed Pharmacy Care, et al. v. Sebelius, et al.*: The Department is prohibited from implementing reductions for pharmacy services. **On March 12, 2012, the district court issued an order modifying the injunction to allow DHCS to apply the payment reduction to services rendered from June 1, 2011 through December 27, 2011, that are reimbursed for the first time on or after December 28, 2011. Both DHCS and plaintiffs have appealed. The parties have completed their briefs regarding the issuance and modification of the injunction, and the hearing on that issue is set for October 10, 2012.**
- January 10, 2012 – *California Medical Transportation Association v. Douglas, et al.*: The Department is prohibited from implementing reductions for non-emergency medical transportation (NEMT) providers. **The court subsequently modified the injunction to allow DHCS to implement the 10 percent reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of the injunction, and the hearing is set for October 10, 2012.**
- January 31, 2012 – *California Medical Association v. Douglas, et al.*: The Department is prohibited from implementing reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment on or after June 1, 2011. **DHCS appealed. The parties have completed and filed their appellate briefs regarding the issuance of the injunction, and the hearing is set for October 10, 2012.**

The Department has filed Notices of Appeals in the first three cases and will do so in the fourth case as well.

A 7 (PC-180) X X

Audit Settlements

Payments for audit settlements with the federal government are budgeted in the Audit Settlements policy change.

OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS

Applicable F/Y

C/Y B/Y

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y											
		<u>C/Y</u>	<u>B/Y</u>										
R 1 (PC-NA)	X	X		<u>FMAP Changes</u>									
<p>The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi-Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004.</p> <p>On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.</p> <p>On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that included a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California received an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date payment occurs, there will be some expenditures made in FY 2011-12 that receive ARRA. Expenditures may receive the applicable FMAP based on date of service, such as SNCP payments, or based on the date another department paid the initial expenditure and Medi-Cal draws the federal funds in a subsequent fiscal year.</p>													
R 2 (PC-172)	X	X		<u>Dental Contract</u>									
<p>The dental rates are:</p> <table><tr><td></td><td>Refugees</td><td>All Others</td></tr><tr><td>August 1, 2010 – July 31, 2011</td><td>\$7.06</td><td>\$6.70</td></tr><tr><td>Effective August 1, 2011 – <u>June 30, 2012</u></td><td>\$3.35</td><td>\$6.03</td></tr></table> <p>AB 97 requires a 10% provider payment reduction. CMS approved the reduction, effective June 1, 2011. The current rates remain in effect until the new rates, reflecting the reduction, are negotiated and approved by control agencies through the change order process.</p>						Refugees	All Others	August 1, 2010 – July 31, 2011	\$7.06	\$6.70	Effective August 1, 2011 – <u>June 30, 2012</u>	\$3.35	\$6.03
	Refugees	All Others											
August 1, 2010 – July 31, 2011	\$7.06	\$6.70											
Effective August 1, 2011 – <u>June 30, 2012</u>	\$3.35	\$6.03											

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 3	(PC-117) (PC-147)	X	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through several dental plans. Currently, there are five four dental GMC plans.</p> <p>The five four GMC contracts are in effect through December 31, 2012. The Request for Application Proposal process for a new contract, effective January 1, 2013, began in January 2012.</p>
R 4	(PC-117) (PC-147)	X	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made a provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis.</p> <p>The Department has contracted with eight seven dental plans that are providing services as voluntary PHPs in Los Angeles County. These contracts ended end on June 30, 2009 2013. Amendments have been executed extending the contracts through June 30, 2013. The Request for Application Proposal process for a new contract, effective July 1, 2013, is expected to begin in July began in January 2012.</p>
R 5	(PC-194)		X	<p><u>FI Cost Containment Projects – Program Savings</u></p> <p>The Department has approved implementation of proposals developed by the Fiscal Intermediary to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.</p>
R 6	(OA-14)	X	X	<p><u>MIS/DSS Contract</u></p> <p>The Management Information System and Decision Support System (MIS/DSS) houses a variety of data and incorporates it into an integrated, knowledge-based system. It is used by the Department, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, the Third Party Liability and Recovery Division in its collection efforts, and the Audits and Investigations Division in its anti-fraud efforts.</p> <p>Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with Integris, Inc. DBA Optuminsight, which is effective through February 14, 2014. <u>The Department plans to continue contracting for MIS/DSS services with Integris beyond the current contract end date of June 30, 2015.</u></p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 7	(PC-186) (Reworded)	X	X	<u>Indian Health Services</u> The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and CMS on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to Native Americans through IHS tribal facilities. Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA. The per visit rate payable to the Indian Health Clinics is adjusted annually through changes posted in the <i>Federal Register</i> .
R 8	(OA-66)	X	X	<u>Kit for New Parents</u> Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.
R 9	(PC-175)	X	X	<u>Developmental Centers/State Operated Small Facilities</u> The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.
R 10	(OA-54)	X	X	<u>CDDS Administrative Costs</u> The Medi-Cal budget includes FFP for CDDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, CDDS began budgeting the General Fund in its own departmental budget.
R 11	(PC-NA) (OA-NA)	X	X	<u>Mental Health Services – CDMH</u> This assumption has been moved to the "Mental Health: Old Assumption" section.
R 12	(PC-NA)	X	X	<u>Healthy Families – CDMH</u> This assumption has been moved to the "Mental Health: Old Assumption" section.
R 13	(PC-NA)	X		<u>Drug Medi-Cal – CDADP</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 14	(PC-187) (OA-57)	X	X	<u>CLPP Case Management Services</u> The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.
R 15	(PC-188)	X	X	<u>Cigarette and Tobacco Products Surtax Funds</u> Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement and Medi-Cal hospital outpatient services via the Hospital Services Account and the Unallocated Account. The amounts available to Medi-Cal vary from year to year.
R 16	(OA-68)	X	X	<u>California Health and Human Services Agency HIPAA Funding</u> A HIPAA office has been established at the California Health and Human Services Agency to coordinate implementation and set policy regulations for departments utilizing Title XIX programs. Title XIX FFP is available for qualifying HIPAA activities related to Medi-Cal.
R 17	(OA-5)	X	X	<u>EPSDT Case Management</u> Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.
R 18	(OA-2) (OA-45)	X	X	<u>CCS Case Management Costs</u> Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children who receive CCS services who are Medi-Cal eligible. The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients in the CCS Medi-Cal, CCS State Only, and CCS-Healthy Families programs. The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate. County funds expended above the allocations on administrative activities in support of a county's CCS/Medi-Cal caseload may be used as certified public expenditures to draw down Title XIX federal financial participation.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 19	(PC-69)	X	X	<u>IMD Ancillary Services – CDMH</u> This assumption has been moved to “Mental Health-Old Assumption” section.
R 20	(OA-33)	X	X	<u>Postage and Printing – Third Party Liability</u> The Department uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi-Cal caseload. Beginning July 2012 the Department will lease a Mail Creation Solution System (MCSS) to process the majority of mailings in-house.
R 21	(OA-46)	X	X	<u>TAR Postage</u> Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.
R 22	(PC-185)	X	X	<u>HIPP Premium Payouts</u> The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective. On January 1, 2008, the State Plan was amended to remove HIV/AIDS as an automatic HIPP-eligible condition. Effective March 1, 2010, the Department discontinued payments for beneficiaries with HIV/AIDS whose premiums exceeded Medi-Cal cost avoidance thresholds.
R 23	(PC-167)	X	X	<u>Medicare Part A and Part B Buy-In</u> The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare. <u>Part B beneficiaries with an unmet share of cost are not eligible.</u> These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year.
R 24	(OA-74)	X	X	<u>PIA Eyewear Courier Service</u> The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y				
<u>C/Y</u> <u>B/Y</u>				
				costs of the courier service that delivers orders between the optical providers and PIA.
R 25	(OA-64)	X	X	<u>FFP for Department of Public Health Support Costs</u>
				Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.
R 26	(PC-174)	X	X	<u>ICF-DD Transportation and Day Care Costs - CDDS</u>
				Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.
				On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.
R 27	(PC-183)	X	X	<u>Non-Contract Hospital Inpatient Cost Settlements</u>
				All non-contract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the non-contract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.
R 28	(PC-137)	X	X	<u>FQHC/RHC/CBRC Reconciliation Process</u>
				The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) participating in the Medi-Cal PPS is applied as follows: Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.

The difference between the interim rate and the payments from managed care plans and Medicare, and the difference between the PPS rate and the payments from CHDP, is reconciled by an annual reconciliation request that is filed by each FQHC/RHC within five months of the close of their fiscal period.

A tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required by W & I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.

W & I Code § 14105.24 requires the Department to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. An interim rate, adjusted after each audit report is final, is paid to the clinics. The CBRCs are then required to submit an annual cost report no later than 150 days after the close of their fiscal year. The Department audits each CBRC's cost report and completes a cost settlement which results in a payment to the CBRC or a recoupment from the CBRC. The Department expects to complete audits and adjust interim rates each fiscal year to the appropriate audited levels.

R 29 (OA-28) X X HIPAA Capitation Payment Reporting Project

The Department currently pays contracted managed care health plans through a manual process which is only capable of reporting capitation amounts at the aid code level or above. HIPAA mandates that these types of payments be reported using a standard HIPAA transaction. New HIPAA transaction requirements were implemented on July 1, 2011.

The new HIPAA transaction requirements (5010) will make significant improvements to the capitation calculation process while allowing detailed reporting at the beneficiary level, which will increase the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans. The electronic storage of the data will also support research efforts to perform recoveries from the estates of deceased Medi-Cal beneficiaries. ~~Phase 1 of the new HIPAA Capitation Payment Reporting Project (CAPMAN) went into production in July 2011.~~ The old manual system needs to be maintained for one year to process net changes.

Since implementation, additional unforeseen functionality is required by CAPMAN. It is anticipated that a new five year contract is required to

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

bring additional state and vendor staff to work with the Department on CAPMAN system changes. ~~Phase 2 will begin in FY 2012-13.~~

R 30 (PC-NA) X

ARRA – Additional FFP for DHCS

This assumption has been moved to “Time Limited/No Longer Applicable” section.

R 31 (OA-23) X X
 (PC-170)
 (PC-FI)

ARRA HITECH Incentive Program

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of ARRA, authorizes the outlay of federal money estimated to be roughly \$45 billion over ten years between 2011 and 2021 for Medicare and Medicaid incentives to qualified health care providers who adopt, **implement or upgrade**, and **meaningfully** use Electronic Health Records (EHR) in accordance with the HITECH Act's requirements. Provider payments are paid with 100% federal funds.

The Department received approval of the State Medicaid Health Information Technology Plan (SMHP) and Implementation Advance Planning Document (IAPD) on September 30, 2011 and was authorized to implement the EHR Incentive Program, which occurred on October 3, 2011.

The Fiscal Intermediary (FI) will design, develop and implement systems necessary to enroll, pay and audit providers and hospitals who participate in the Medi-Cal EHR Incentive Payments Program.

The Department will expand the current MMIS Health Information Exchange (HIE) for e-prescribing to ensure Medi-Cal providers are qualified for meaningful use of their electronic health records and to add automated consent features available to the Medi-Cal beneficiary community.

The Department is required by CMS to implement certain technical assessments and demonstration projects in order to understand the current usage of and barriers to EHR adoption and meaningful use, by providers and hospitals throughout the state. Multiple contractors are required in order to complete the projects and assessments.

The HITECH Act establishes a 90% federal funding match specific to the state for this work. ~~The~~ **For most administrative projects and activities, the** 10% General Fund match will be reimbursed by funding from outside entities. ~~Therefore, there will be no impact to the General Fund.~~ **For those administrative projects that are not matched from outside funds, AB 1467 (Chapter 23, Statutes of 2012) provides for \$200,000 from the General Fund annually for those state administrative costs.**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 32	(PC-NA)	X	X	<u>Reduction in IMD Ancillary Services Costs</u>
				This assumption has been moved to the "Time Limited/No Longer Applicable" section.
R 33	(OA-NA)			<u>Emily Q. – Special Master</u>
				This assumption has been moved to "Time Limited/No Longer Applicable" section.
R 34	(OA-44)	X	X	<u>Katie A. v. Diana Bontá – Special Master</u>
				This assumption has been moved to the "Mental Health-Old Assumption" section.
R 35	(OA-37)	X	X	<u>Encryption of PHI Data</u>
				The Department acquired hardware, supplies and associated maintenance and support services that are necessary to encrypt electronic data stored on backup tapes. The data on these tapes contain Medi-Cal beneficiary information that is considered confidential and/or protected health information (PHI) by federal and state mandates.
				The encryption of these tapes will:
				<ul style="list-style-type: none"> • Secure and protect Department information assets from unauthorized disclosure, • Protect the privacy of Medi-Cal beneficiaries, • Prevent lawsuits from citizens for privacy violations, • Avoid costs to notify millions of people if a large breach does occur, and • Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.
R 36	(PC-NA)	X	X	<u>Federal Flexibility and Stabilization - Additional Federal Reimbursement</u>
				This assumption has been moved to "Time Limited/No Longer Applicable" section.
R 37	(PC-182)	X	X	<u>ICF-DD Administrative and QA Fee Reimbursement - CDDS</u>
				The Department of Developmental Services (DDS) will make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center consumers. The

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

services and transportation are arranged for and paid by the local Regional Centers, which will bill DDS on behalf of the ICF-DDs. A State Plan Amendment (SPA) was approved April 15, 2011. DDS will provide payment, retroactive to July 1, 2007, to the ICF-DDs for the cost of reimbursing the Regional Centers for the cost of arranging the services plus a coordination fee (administration fee and the increase in the QA fee).

On April 8, 2011, the Department entered into an interagency agreement with DDS for the reimbursement of the increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

R 38 (PC-NA) X X Discontinue Part B Premium for Unmet Share of Cost Beneficiaries

This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.

R 39 (PC-189) X X CLPP Funds

Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.

R 40 (PC-195) X X Overpayments – Interest Rate Change

The Department assesses interest on overpayments made to Medi-Cal providers at a rate equal to the monthly average received on investments in the Surplus Money Investment Fund (SMIF). ~~The current SMIF rate is 0.38%, which is below the commercial borrowing rate.~~ **AB 1467 (Chapter 23, Statutes of 2012) authorizes the Department to update the interest rate to the California Constitution rate or the SMIF rate, whichever is higher.**

~~The Department has proposed legislation to change the interest rate to the rate authorized by the California Constitution or the SMIF rate, whichever is higher. As a result of the rate change, the Department anticipates receiving increased revenue.~~

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
R 41	(PC-131) (PC-132) (PC-133) (PC-134) (PC-135)	X	<u>Payment Deferral</u> Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. The Department is proposing language to delay an additional checkwrite for FY 2012-13. From then on, two checkwrites would be delayed at the end of each fiscal year. The checkwrite normally paid on June 20, 2013 would be paid in July 2013. This delay will result in a decrease in expenditures estimated to be \$355.2 million TF in FY 2012-13. In addition to delaying a checkwrite, the Department is also proposing to delay one month of managed care capitation rates in FY 2012-13. This delay will result in a decrease in expenditures estimated to be \$1,230.0 million TF in FY 2012-13.
R 42	(PC-68)	X X	<u>Siskiyou County Mental Health Plan Overpayment</u> This assumption has been moved to the "Mental Health-Old Assumption" section.
R 43	(PC-NA)	X	<u>Refunds on Acts of Fraud</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.
R 44	(OA-7)	X X	<u>CalHEERS Development</u> This assumption has been moved to "Affordable Care Act-Old Assumption" section.
R 45	(OA-26)	X	<u>MEDS Integration into CalHEERS</u> This assumption has been moved to "Affordable Care Act-Old Assumption" section.
R 46	(PC-191)	X	<u>First 5 California Funding</u> In FY 2012-13, \$40,000,000 of First 5 California funding, will be reimbursed to Medi-Cal through an interagency agreement.
R 47	(PC-168)	X X	<u>Part D—Phased-Down Contribution</u> With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual CMS-determined inflation factor, and PMPM are adjusted annually.

R 48 (OA-61) X X CDPH I&E Program and Evaluation

AB 1762 (Chapter 301, Statutes of 2003) authorized the Department to require contractors and grantees under ~~the Office of Family Planning,~~ and the Information and Education (I&E) program to establish and implement clinical linkages to the Family PACT program, effective in the 2003-04 fiscal year. This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services.

The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.

R 49 (PC-193) X X Operational Flexibilities

The Department will establish policies to improve Medi-Cal processes through operational flexibilities.

OTHER: RECOVERIES: NEW ASSUMPTIONS

Applicable F/Y

C/Y

B/Y

OTHER: RECOVERIES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
RC 1	(PC-202)	X	X	<u>Base Recoveries</u>
Medi-Cal recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, lawsuit settlements , providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances. Recoveries are based on trends in actual collections.				
RC 2	(PC-NA)	X	X	<u>Anti-Fraud Initiative</u>
This assumption has been moved to the "Fully Incorporated into Base Data/Ongoing" section.				
RC 3	(PC-199)	X	X	<u>FQHC/RHC Audit Staffing</u>
The Department received three limited-term positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. In the past five years, the number of FQHC/RHC providers has increased from 460 to 1,000, while the number of audit staff has remained the same. The positions were filled in December 2011, but will expire expired on June 30, 2012. Due to the expiration of the positions, only limited savings is anticipated. <u>The Department redirected existing staff to continue to perform these audit activities.</u>				
RC 4	(OA-17)	X	X	<u>Medi-Cal Recovery Contract</u>
The Department contracts with vendors to identify third party health insurance and workers compensation insurance. When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries.				
RC 5	(PC-197)	X	X	<u>Anti-Fraud Activities for Pharmacy and Physicians</u>
In FY 2011-12, the Department expanded its anti-fraud activities. The activities focus on pharmacy and physician services.				
RC 6	(PC-196) (OA-35)	X	X	<u>Medicare Buy-In Quality Review Project</u>
On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the buy-in process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums. The Department anticipates it will begin realizing savings in FY 2011-12 2012-13 . Payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers.				

FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS

Applicable F/Y			
	<u>C/Y</u>	<u>B/Y</u>	
FI 0.1 (OA-49)	X	X	<u>SDMC System M&O Support</u> The Department has started procuring a contract for ongoing operation and maintenance of the Short-Doyle/Medi-Cal (SDMC) system. The SDMC system adjudicates Medi-Cal claims for specialty mental health and substance use disorder services. This contract will be for a two year period beginning June 29, 2013, with three one-year optional extensions.
FI 0.2 (OA-50)	X	X	<u>Annual EDP Audit Contractor</u> The Department plans to procure an independent Certified Public Accounting firm to provide a contractually required annual Electronic Data Processing (EDP) audit of the Medi-Cal fiscal intermediary. The Department will use the findings and recommendations of the audit as part of its ongoing CA-MMIS monitoring process.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-FI) (PC-194)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>The Department continues to review and approve the Fiscal Intermediary-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with the Fiscal Intermediary continuing to receive a share of the savings.</p> <p>Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.</p>
FI 2	(PC-FI)	X		<p><u>HIPAA – Provider Relations</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
FI 3	(PC-FI)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>Implementation of the original scope of the Universal Product Number (UPN) pilot project was cancelled in March of 2006 because it was determined that the modifications to the current CA-MMIS infrastructure would be too costly and could not be implemented in an efficient manner. Further analysis determined that in order to implement the use of the UPN into a claims processing environment, it would be necessary to bring forth new technology in order to allow for the system to be flexible, cost effective, and easily modified for future requirements.</p> <p>The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the National Drug Code (NDC). CMS is requiring a two-year evaluation of the project to substantiate the possible adoption of the UPN as a HIPAA standard. The Department completed the two-year evaluation of the UPN and submitted findings to CMS in September 2011. Additional work will be required in FY 2012-13 to ensure Medi-Cal continues using the UPN on medical supply claims and assist in activities necessary to adopt the UPN as a HIPAA standard. <u>There will be a FY 2012-13 cost if the Federal government requires the Department to discontinue the use of the UPN.</u></p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/YB/YFI 4 (PC-FI) X X HIPAA – CA-MMIS

HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff is required to provide for remediation/implementation of HIPAA changes to the CA-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The necessary work is associated with the following HIPAA regulations:

- **Privacy (Completed)**
- Transactions and Codes (~~October 16, 2003 compliance deadline~~) **(Completed)**
- **Unique Employer Identifier (Completed)**
- Security (~~April 21, 2005, compliance deadline~~) **(In Progress)**
- **National Provider Identifier (Completed)**
- Electronic Signature (~~Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM~~) **(Future Project)**
- Enforcement (~~March 16, 2006 effective date~~) **(Completed)**
- National Health Plan Identifier (~~NPRM pending~~) **(Future Project)**
- Claims Attachments (~~Final Rule pending~~) **(Future Project)**
- First Report of Injury (~~NPRM pending~~) **(Future Project)**
- Transactions and Code Sets Revisions (~~Final Rules published January 16, 2009~~) **(In Progress)**

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented. The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013.

FI 5 (PC-FI) X X Extension of the HP Contract

The Department contracts with HP up to June 30, 2012 to allow for the completion of all post operation activities. **The Department extended**

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

the HP contract one year, up to June 30, 2013, for the sole purpose of providing payment to HP for a cost containment proposal. The payment is for services performed during the original term of the contract.

FI 6 (OA-40) X

Medicaid Information Technology Architecture

The CMS is requiring the Department to create frameworks and technical specifications for the MMIS of the future. CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through Medicaid Information Technology Architecture (MITA) the Department will develop the ability to streamline the process to access information from various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.

The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements. The Department must ~~now~~ complete a MITA Transition and Implementation plan by July 1, 2012, to retain the enhanced funding for the SS-A **an annual SS-A that contains a roadmap that demonstrates progression along the MITA model.** The Department is currently developing Enterprise Architecture (EA) at the Agency level to address MITA EA activities.

FI 7 (OA-18) X X

CA-MMIS Takeover and Replacement Oversight

CA-MMIS is the claims processing system used for Medi-Cal. This system has changed considerably over the past 30 years to incorporate technological advances as well as address new business and legislative requirements and, as a result, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a detailed assessment was completed by a specialty vendor which recommends that modernization of CA-MMIS begin immediately. The Department contracts with various vendors to assist with FI oversight activities, documentation of business rules, project management, change management and IV&V services during transition and replacement of the CA-MMIS.

FI 8 (PC-FI) X

Medi-Cal Fiscal Intermediary Contract Turnover

This assumption has been moved to the "Time Limited/No Longer Applicable" section.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/YB/Y

FI 9 (PC-FI) X

CA-MMIS Takeover by New FI Contractor

CA-MMIS is the claims processing system used for Medi-Cal and is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department extended the term of the ~~current~~ **previous** contract ~~up to~~ June 30, 2012 to continue uninterrupted support of ~~ongoing operations until a successful AOO by the new FI contractor~~ **contractor's Takeover phase**. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published on December 8, 2009. The Takeover activities of the new FI contractor began on May 3, 2010. In the Takeover Phase, the new FI is required to complete contractually required activities necessary for the AOO from the current contractor. These activities include the following expansion items:

- On-line and Computer-Based Interactive Training,
- Post-Service Prepayment Audit,
- Contingency Payments,
- Caller Satisfaction Evaluation Tool,
- Encounter Data Processing,
- Geographic Mapping,
- Contract Management,
- CA-MMIS Enterprise Project Management Office,
- Project and Portfolio Management,
- Additional Software Licenses,
- Additional Office Space,
- Security for Data "At Rest",
- Additional 32-Bit Processors,
- Payment Methodology Modification,
- Sensitive Information Redaction.

Takeover plans ~~are~~ **were** expected to be completed in FY 2011-12; **however final documentation of Takeover is still being finalized. As a result, the final payment for Takeover will occur in FY 2012-13.**

FI 10 (OA-20) X X

CA-MMIS Takeover/Replacement Other State Transition Costs

CA-MMIS is the claims processing system used for Medi-Cal. The ~~current~~ **previous** FI contract ~~was scheduled to end on June 30, 2011. The Department extended the term of the current contract up to~~ **will expire on** June 30, 2012 ~~through a contract amendment utilizing a non-competitive bid justification~~ **2013**. Additional costs will be incurred for CA-MMIS Takeover and Replacement activities which include interfacing with other Departmental mission critical systems such as MEDS, EMBER, SCO, MIS/DSS and PCES applications that will require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

environments (including system and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Takeover and Replacement phases. The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during both phases. The Takeover activities are expected to be completed in FY ~~2011-12~~ **2012-13**, and Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS replacement phase.

FI 11 (PC-FI) X X Business Rules Extraction Enhancement

The objective of the Business Rules Extraction (BRE) Enhancement is to define a new rules base for the legacy MMIS and store the rules, once confirmed, in a requirements traceability tool for tracking future testing management and updating. The existing business rules for CA-MMIS are not well documented and may not fully represent current Medi-Cal policy. It is the Department's intent to implement the Replacement System with the current business rules and program policy, to support validation of the Replacement System functionality, and then update the system through policy directives to the Contractor, based on the Contractor's report of the BRE. The Confirmed Legacy System business rules will also be incorporated into the Replacement System design. The Contractor will develop this policy base through analysis of business rules embedded in the legacy CA-MMIS and compare the policy base with published Department policy manuals. The Contractor will identify discrepancies between the system embedded rules and current Department policy and recommend a course of action. The Department will determine the appropriate course of action and direct the Contractor on this course. The Department will verify and validate the business rules only after the Contractor has completed its detailed analysis. The Department plans alternative approaches to BRE that streamline the resources and time required for BRE. ~~This results in an adjustment of BRE estimates. BRE may~~ **will** occur as part of the CA-MMIS replacement efforts, as opposed to a separate one time effort through system Enhancement. Costs related to BRE activities are ~~not~~ expected ~~until~~ **to start in** FY 2012-13.

FI 12 (PC-FI) X X CA-MMIS Re-Procurement – HIPAA ICD-10 Legacy Enhancement

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

Coding System (ICD-10-PCS) for inpatient hospital procedure coding. Medi-Cal currently uses ICD-9 coding, as does the majority of the national health care industry, as critical data for claims processing, prior authorization, fraud investigation, and other program operations. The Final Rule for ICD-10 indicates an expectation that efforts to begin addressing these requirements begin no later than January 2011; the compliance deadline is October 1, 2013.

The new contract for the CA-MMIS was awarded to ~~Affiliated Computer Services (ACS)~~ **Xerox**, and includes an enhancement of the existing system to address ICD-10 requirements. Planning, analysis, development and implementation of the CA-MMIS ICD-10 enhancement is in process.

FI 13 (PC-FI) X X CA-MMIS Re-Procurement – 5010/D.0 Legacy Enhancement

As part of the HIPAA, the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt new versions of the standards for electronically exchanging critical administrative health care transactions, including health care claims, eligibility information, prior authorizations, and payment information. These changes will impact the vast majority of Medi-Cal providers and managed care plans. These new versions are maintained by two national standards organizations; X12 and the National Council for Prescription Drug Programs (NCPDP). ~~The~~ X12's transactions are part of ~~the~~ standard called "5010," while NCPDP's standard is called "D.0". The ~~federal~~ compliance deadline ~~is~~ **was** January 1, 2012; **however, the activities will continue until December 31, 2012.**

The new contract for the CA-MMIS was awarded to ~~ACS~~ **Xerox**, and includes an enhancement of the existing system to address the 5010/D.0 transaction requirements. The planning, analysis, and development of the CA-MMIS 5010/D.0 has been completed. Implementation into CA-MMIS ~~is scheduled for~~ **was** July 1, 2012. **The Department will allow Medi-Cal providers to continue to submit claims in the old format for a period of time.**

FI 14 (PC-FI) X TAR/SAR System Replacement (pharmacy-only)

The Department will replace the existing Treatment Authorization Request (TAR) System **for pharmacy services only and** establish two TAR Processing Centers and consolidate existing Field Office Automation Group (FOAG) activities. ~~The CMS Net and Service Authorization Request (SAR) functionality, including the help desk, will also be replaced by the new TAR system.~~ **Remaining TAR services (non-pharmacy) and CMS Net functionality will be replaced at a future date as part of subsequent replacement phases. Pharmacy TAR/SAR replacement DD&I is scheduled to begin in February 2012,**

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/YB/Y

and implementation of the system will begin within two years of assumption of operations by the new FI **May 2013; however, actual costs will not be incurred until FY 2013-14.**

FI 15 (PC-FI) X X Pharmacy Claims/DUR/Rebate Accounting Replacement

The Department will implement a new pharmacy claims system that will include three major components: real-time Point-of-Service (POS) and batch claims processing; the rebate collection and tracking system; and drug utilization review (both prospective and retrospective). ~~Work~~ **Planning work** on the system began in January 2012, and implementation of the system ~~will begin within two years of assumption of operations by the new FI~~ **will occur prior to June 30, 2014.**

FI 16 (PC-FI) X X Rebate Accounting and Information System Hardware and Software Refresh

The Rebate Accounting and Information System (RAIS) supports invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.

RAIS is built upon technology that is client server oriented. Since the hardware technology is constantly changing and expanding, the hardware has a limited life span. In order to avoid memory storage reaching maximum capacity and hardware components failing due to the age of the equipment, the FI Contractor is required to evaluate RAIS hardware and software every five years. The last refresh of the RAIS platforms was completed in 2005. The FI Contractor's review of RAIS determined that the RAIS hardware has reached its end of life. The refresh is expected to ~~take place~~ **begin** in FY ~~2011-12~~ **2012-13.**

FI 17 (PC-FI) X Provider Enrollment Automation Project

This assumption has been moved to the "Information Only" section.

FI 18 (PC-FI) X X Point of Service Refresh

Medi-Cal providers are currently able to use the Point of Service (POS) devices to verify Medi-Cal recipients' eligibility, and perform claims-related transactions including: decrement Share of Cost (SOC), submit pharmacy transactions for immediate on-line adjudication, access the Child Health and Disability Prevention Gateway, and submit Family Planning, Access, Care and Treatment transactions.

The devices that support the POS network are out-of-date and need to be replaced to comply with the new HIPAA transactions standards. Implementation of the POS refresh is scheduled to be completed in June 2013.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 19	(PC-FI)	X	X	<u>FI Assumption of Operations Delay Reimbursement</u> This assumption has been moved to the "Information Only" section.
FI 20	(PC-FI)	X	X	<u>Additional Resources to Support CSU Operations</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.
FI 21	(PC-FI)	X	X	<u>Family PACT Retroactive Eligibility Claim Process</u> This assumption has been moved to the "Withdrawn" section.
FI 22	(PC-FI)	X		<u>Additional Costs Associated with Delay in AOO</u> This assumption has been moved to the "Time Limited/No Longer Applicable" section.
FI 23	(OA-38)	X	X	<u>MIS/DSS Contract Reprocurement Services</u> The contract for ongoing development, maintenance, and operation of the Management Information System and Decision Support System (MIS/DSS) is scheduled to end on February 14, 2014. The Department will contract with a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract beginning in FY 2011-12 2012-13 . Resources are needed to develop the required project approval documents (FSR/APD) Feasibility Study Report and APD to achieve required state and federal level approvals.
FI 24	(PC-FI)	X		<u>Clarity Software</u> The federal health reform initiatives require the Department to effectively and efficiently initiate, manage, monitor and report human and cost resources. Clarity is a portfolio management tool designed for prioritization, efficiency, and analysis. This tool will help the Department manage the various technology undertakings that are required to make improvements to the Medi-Cal fiscal intermediary process and for implementing the new California Medicaid Management Information System (CA-MMIS), which will bring additional efficiencies and functionality to support the Medi-Cal program.
FI 25	(PC-FI)	X		<u>Additional CA-MMIS Office Space</u> The Department has decided to locate all CA-MMIS staff in one facility location and has directed ACS Xerox to provide additional office space within the new Medi-Cal Operations Center (MOC) facility in West

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

Sacramento, CA. This office space exceeds the FI's contractual office space requirements. The build out of additional office space is expected to be completed by FY ~~2011-12~~ **2012-13**.

FI 26 (PC-FI) X

Termination of Convenience

This assumption has been moved to the "Time Limited/No Longer Applicable" section.

FI 27 (PC-FI) X X

Cost Reasonableness Contractor

In accordance with the ACS ~~Xerox~~ contract, the Department plans to procure a Cost Reasonableness contractor. The contractor **will** evaluate the reasonableness and accuracy of any Systems Development Notice, Change Order, or Enhancement cost estimates submitted by the FI Contractor. ~~Procurement is anticipated to be completed~~ **The Department anticipates completing the procurement** in October 2012.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS

Applicable F/Y

C/Y

B/Y

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X	X	<u>Personalized Provider Directories</u> HCO currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 (Chapter 188, Statutes of 2007) authorized the implementation of a Personalized Provider Directory (PPD) as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009 and continued for a period of two years. At the end of the pilot project period (March 2011), the Department, in consultation with health plans and stakeholders, performed an assessment to determine if Personalized Provider Directories provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, and if they should be implemented statewide in all managed care counties. This determination will be based on the outcomes set forth in the evaluation provided to the Legislature. The pilot project will continue beyond the initial two year period until this determination is made.
HO 2 (PC-FI)	X		<u>Additional Contractual Service – Initial Health Screen Questionnaire</u> This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.
HO 3 (PC-FI)	X	X	<u>SPD Mandatory Enrollment into Managed Care HCO Costs</u> This assumption has been moved to the “Time Limited/No Longer Applicable” section.
HO 4 (OA-42)	X	X	<u>Health Care Options Consultant Costs</u> The Department will contract with a health care consultant to identify the best practices used in other states with enrollment broker contracts, determine the impact of Health Care Reform on the HCO program, and assist in evaluating all options regarding enrollment <u>develop policies, make recommendations, and provide assistance in aligning its Health Care Options Program with Health Care Reform and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) solution.</u> Operations for the current enrollment broker contacts ends on September 30, 2012, with three one-year extension options.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
HO 5 (PC-FI)	X	<u>Updates to Existing HCO Informing Materials</u>	
<p>All existing HCO informing materials will be reviewed and revised to reflect changes associated with the current health care environment. This includes, but is not limited to:</p> <ul style="list-style-type: none">• Current managed care requirements,• New program needs and modifications,<ul style="list-style-type: none">◦ Shifts from voluntary to mandatory eligibility requirements◦ Changes in plan or provider eligibility• Compliance with Federal Health Care Reform law. <p>All informing materials used by the Department in the Medi-Cal Managed Care HCO program will be updated. The updates will generate costs for production, printing, and threshold language translations.</p>			
HO 6 (PC-FI)	X	<u>Health Plan of San Joaquin Replacing Anthem Blue Cross as LI in Stanislaus County</u>	
<p>Stanislaus County currently designates Anthem Blue Cross as the Local Initiative (LI) health plan. Through a request for proposal, the County selected Health Plan San Joaquin (HPSJ) as the new designated LI. Notices and packets will be mailed to all beneficiaries to coincide with a January 1, 2013 start date for HPSJ. The first notice will be mailed in September 2012.</p>			

FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
DD 0.1 (PC-FI)	X			<u>Extension of the Current Medi-Cal Dental FI Contract</u> <p>CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. Consequently, this prohibits the contract from receiving enhanced FFP. The Department exercised a one-time extended operations option of the current contract for the period of July 1, 2012 through June 30, 2013, to work with CMS in developing a planning document to make the system certifiable as an MMIS and compliant with the Federal Register Vol. 76, No. 75.</p> <p>All Runout and Underwriting Periods will be adjusted accordingly and all related activities for the new FI contract will be delayed.</p>
DD 0.2 (OA-34)	X	X		<u>APD–Project Manager</u> <p>The Department completed the procurement for the CD-MMIS Fiscal Intermediary and published the Notice of Intent in August 2011. CMS determined the dental contract no longer meets the regulatory criteria and conditions as a MMIS acquisition. Therefore, the contract is not eligible for enhanced FFP at 75%.</p> <p>The Department plans to procure a Certified Project Manager (CPM) to develop and obtain CMS approval of an Advanced Planning Document (APD). The Project Manager's responsibilities include:</p> <ul style="list-style-type: none"> • Provide project management expertise, • Provide status reporting, and • Advise the Department to ensure CMS approval of the dental FI contract as an MMIS at the enhanced level.

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

DD 1 (PC-FI) X X

HIPAA – CD-MMIS

HIPAA requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Dental Medicaid Management Information System (CD-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high-level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Electronic Signature (~~Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM~~) **(Completed)**
- Enforcement (~~March 16, 2006 effective date~~) **(Completed)**
- National Health Plan Identifier Standard (~~NPRM pending~~) **(Pending)**
- Claims Attachments (~~Final rule pending~~) **(Pending)**
- First Report of Injury (~~NPRM pending~~) **(Completed)**
- Transactions and Code Sets Revisions (~~Final Rules published January 16, 2009~~) **(In Progress)**
- Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claims Transactions (~~Interim Final Rule published July 8, 2011~~) **(In Progress)**
- **Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance (In Progress)**

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased in approach to implement the most critical transactions (in terms of provider impact) and code sets first, without interrupting payments to providers or services to beneficiaries. The January 16, 2009 published HIPAA rules require CD-MMIS changes in order to incorporate updated ASC X12 5010 transactions for dental claims by the federal compliance date of January 1, 2012. The July 8, 2011 published HIPAA rules require changes to the Claim Status Companion Guides and have a compliance date of January 1, 2013.

DD 2 (PC-FI) X X

Medi-Cal Dental FI Contract Turnover

The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

addition to supporting the Department's procurement effort by ensuring that all required data and documentation was included in the Office of Medi-Cal Procurement's data library. Turnover support services and all activities in accordance with the contract requirements ~~commenced on January 4, 2010 and will continue through June 30, 2012~~ **are being delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.**

DD 3 (PC-FI) X X

CD-MMIS Takeover by New Dental FI Contractor

The CD-MMIS is the Medi-Cal dental claims processing system operated by the dental FI. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published in August 2011. The takeover activities for the new dental FI contractor began in February 2012; **however, the Department is exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013. Any further Takeover activities will be delayed. Costs for Takeover activities already completed may be incurred at 50% FFP.** In the Takeover Phase, the new FI is required to complete contractually required activities necessary to ensure a timely and accurate takeover of the existing MMIS.

DD 4 (PC-FI)

X

CD-MMIS Business Rules Extraction Enhancement

The Business Rules Extraction (BRE) enhancement will identify and extract the business rules in the current legacy CD-MMIS and store the rules in a requirements traceability tool for tracking, future testing, managing and updating.

The Department will hire a contractor to develop a traceability matrix of forward and backward contextual links between the various requirements and the work products developed for implementation, as well as to verify the completeness and accuracy of the requirements. All requirements will be captured including: business, user, functional and test requirements for the entire system.

The CD-MMIS Business Rules Extraction enhancement activities will be delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 5 (PC-FI)	X	X	<p><u>Dental Managed Care Encounter Data Enhancement</u></p> <p>The federal government is requiring that HIPAA-covered entities adopt new versions of the transaction requirements (5010) for electronically exchanging critical administrative health care data. The Medical FI, ACS Xerox is enhancing CA-MMIS to address the 5010 requirement. The Dental Managed Care Plans will submit encounter data to the Medical FI in the new standard transaction formats. The Medical FI will pass the encounter data to the Dental FI, consequently CD-MMIS must be enhanced to accept the new format from CA-MMIS.</p> <p><u>However, the DMC encounter data enhancement activities will be delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.</u></p>
DD 6 (PC-FI)		X	<p><u>Medi-Cal Dental FI Contract - Runout</u></p> <p>The Medi-Cal Dental FI contract ends <u>was scheduled to end</u> on June 30, 2012; <u>however, since the Department is exercising the one-time extended operations option of the current Dental FI Contract for the period of July 1, 2012 to June 30, 2013, all Runout activities will be delayed.</u> The Runout period for TARs and claims will begin July 1, 2012. The contractor is required to process TARs and claims with dates of service prior to July 1, 2012 and will continue to do so for fifteen months, ending in September 2013. The new Medi-Cal Dental FI contractor will process TARs and claims beginning July 1, 2012.</p>
DD 7 (PC-FI)	X	X	<p><u>Implementation of New Federal ACA Rules (Federal Register Vol. 76, No. 22)</u></p> <p>This assumption has been moved to the "ACA: Old Assumptions" section.</p>

INFORMATION ONLY:**GENERAL FUND REVENUES****1. General Fund Revenues**

The State is expected to receive the following revenues ~~from quality assurance fees~~ (accrual basis):

FY 2011-12:	\$ 22,221,000	<u>23,037,000</u>	ICF-DD Quality Assurance Fee
	\$ 469,014,000	<u>466,978,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
			(The revenues for this is now included in the revenues for AB 1629.)
	\$ 28,640,000		ICF-DD Transportation/Day Care Quality Assurance Fee
	\$ 2,246,000	<u>999,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
	\$ 265,213,000		Gross Premium Tax (AB 1422)
	\$ 2,568,524,000	<u>2,634,924,000</u>	Hospital Quality Assurance Revenue Fund (4260-610-3158)
	\$ 7,151,000		Emergency Medical Air Transportation (EMATA) Fund
	\$3,363,009,000	<u>3,426,942,000</u>	Total
FY 2012-13:	\$ 22,740,000	<u>23,170,000</u>	ICF-DD Quality Assurance Fee
	\$ 552,818,000	<u>526,707,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 6,620,000		ICF-DD Transportation/Day Care Quality Assurance Fee
	\$ 4,585,000	<u>1,256,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
	\$ 435,505,000	<u>364,348,000</u>	Gross Premium Tax
	\$2,848,676,000	<u>2,915,076,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	\$ 7,151,000		Emergency Medical Air Transportation (EMATA) Fund
	\$3,878,065,000	<u>3,844,328,000</u>	Total
<u>FY 2013-14:</u>	<u>\$ 23,153,000</u>		<u>ICF-DD Quality Assurance Fee</u>
	<u>\$ 526,510,000</u>		<u>Skilled Nursing Facility Quality Assurance Fee (AB 1629)</u>
	<u>\$ 6,620,000</u>		<u>ICF-DD Transportation/Day Care Quality Assurance Fee</u>
	<u>\$ 1,258,000</u>		<u>Freestanding Pediatric Subacute Quality Assurance Fee</u>
	<u>\$ 484,718,000</u>		<u>Gross Premium Tax</u>
	<u>\$3,181,559,000</u>		<u>Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)</u>
	<u>\$ 7,151,000</u>		<u>Emergency Medical Air Transportation (EMATA) Fund</u>
	<u>\$4,230,969,000</u>		<u>Total</u>

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee is assessed, to include Medicare for AB 1629 facilities.

The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of \$22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated \$6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

INFORMATION ONLY:

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of all Medi-Cal managed care plans. The provision pertaining to this tax will be effective retroactive to January 1, 2009 until June 30, 2012. The Department is proposing legislation that will eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal managed care plans. The permanent extension of the tax will generate additional General Fund revenue.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund will be used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund will also be used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to enactment of a new hospital QAF that results in FY 2011-12 revenue for children's services of at least \$320 million.

SB 335 (Chapter 286, Statutes of 2011) authorizes the implementation of a new Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program will authorize the collection of a quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue and will be used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which will result in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations. ~~Upon CMS approval, the Department will provide two supplemental payments in April and September 2012 for FFS Medi-Cal air medical transportation services. Effective July 1, 2012 and for each FY thereafter until January 1, 2018, the Department will augment air medical transportation rates.~~

2. Redevelopment Agency and Local Government Funds

The amended 2009 Budget Act included a \$3.6 billion expenditure transfer of Redevelopment Agency and local government funds to the General Fund to offset General Fund expenditures. Of the \$3.6 billion transfer, \$572,638,000 has been attributed to the Medi-Cal program for accounting purposes. The transfer provides funds directly to the General Fund, and cash does not flow through the Department of Health Care Services. The transfer does not affect Medi-Cal payments or the estimate.

INFORMATION ONLY:**ELIGIBILITY**1. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to ~~February 29~~ **December 31**, 2012 by HR 3765 ~~3630~~, the ~~Temporary Payroll Tax Cut Continuation Act of 2011~~ **Middle Class Tax Relief and Job Creation Act of 2012**.

2. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended February 29, 2012 by HR 3765, the Temporary Payroll Tax Cut Continuation Act of 2011.

3. Lomeli, et al., v. Shewry

On January 20, 2011, the Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit. The petitioners in *Lomeli* alleged that the Department does not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage and demanded the Department to provide those applicants a meaningful opportunity to apply for retroactive Medi-Cal coverage. The settlement requires the Department to send notices to all new SSI applicants who have not had Medi-Cal eligibility in three consecutive months before applying for SSI. The Department will also send notices to new SSI beneficiaries informing them of the availability of retroactive coverage.

The Department implemented the changes in August 2011. The petitioners claim that the Department is required to pay for their attorney fees in excess of \$168,000. The Department, through the Attorney General's Office, is in negotiations with the petitioners.

4. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncoded language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. ~~Because the current state-only long-term care program is available to eligible new applicants and does not include the expenditure limit, the Department is taking steps to bring the current program into conformance with SB 708. This will require the Department to rescind outdated regulations, and implement new regulations to define the spending limit and to clarify other implementation requirements.~~ Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected in ~~FY 2011-12 and FY 2012-13~~ **and FY 2013-14** due to the spending limit.

INFORMATION ONLY:5. Limitation of IHSS Services

The Department of Health Care Services provides the Title XIX FFP to CDSS, via interagency agreements, for the federal share of IHSS personal care services provided to Medi-Cal beneficiaries.

Effective November 1, 2009, CDSS will limit the provision of IHSS domestic and related services to individuals with a functional index score of 4.0, and eliminated all services for individuals with a functional index score of 2.0 and below, with the exceptions of paramedical services, protective supervision, and services for recipients receiving more than 120 overall hours per month.

On October 19, 2009, the federal court issued a preliminary injunction against the reduction.

6. Ledezma v. Shewry Lawsuit

The Department is currently negotiating a settlement of the *Ledezma v. Shewry* lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not expected to be significant. The parties have ~~tentatively agreed to a process determining~~ **determined** the scope of possible ~~Department~~ **the Department's** liability by contacting beneficiaries who may have incurred out-of-pocket expenses. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.

7. Electronic Asset Verification Program

Due to the requirements imposed by H.R. 2642 of 2008, the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to financial institutions. The Department will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The financial vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. There will be undetermined costs for a third party contract as well as reimbursements to financial institutions. Although savings from asset and eligibility verification are currently indeterminate, savings/cost avoidance will be achieved when supplemental data increases the accuracy of eligibility determinations for the ABD population. The implementation date of this program is currently unknown.

AFFORDABLE CARE ACT**BENEFITS**1. State-Only Anti-Rejection Medicine Benefit Extension

Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.

INFORMATION ONLY:**2. CDSS IHSS Share-of-Cost Buyout**

The CDSS and the Department implemented a process that enabled Medi-Cal IHSS recipients who had a Medi-Cal SOC higher than their IHSS SOC to pay the IHSS SOC. Without the payment from CDSS each IHSS recipient with a Medi-Cal SOC that exceeded his/her IHSS SOC was required to meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

An Interagency Agreement between CDSS and CDHS established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.

Effective October 2009, the SOC Buy-Out provision ended, however the reconciliation process of outstanding claims will continue up to the allowable claiming period.

3. California Children's Services (CCS) Program Pilots

The Department will develop and implement four organized health care delivery models to serve CCS eligible children in at least four geographical locations within the State. This effort is a major component of the BTR with CMS and will secure additional federal financial participation for the five year life of the Waiver. The four organized health care delivery systems to be tested during the course of the Waiver are: an enhanced primary care case management model; an accountable care organization model; an existing Medi-Cal managed care organization; and a specialty health care plan. In the pilot counties, administrative work traditionally performed by counties for these children will be performed by the pilot contractor. Implementation of the pilots will begin January 2012.

HOME & COMMUNITY BASED-SERVICES**1. AB 398—Traumatic Brain Injury**

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project.

2. Self-Directed Services Waiver - CDDS

This assumption has been moved to H13: Additional Services for HCBS Clients assumptions.

3. Assisted Living Waiver Expansion

AB 499 (Chapter 557, Statutes of 2000) required the Department to develop a waiver program to test the efficacy of providing assisted living as a Medi-Cal benefit for elderly and disabled persons in Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). In June 2005, CMS approved the Assisted Living Waiver (ALW) Pilot Project and in March 2009 approved the renewal of the waiver for a five-year period. This increased the waiver capacity beginning in FY 2011-12. Vacant slots are continually backfilled.

~~The waiver participants in the pilot counties of Los Angeles, Sacramento and San Joaquin and the expansion counties of Fresno, Riverside, and San Bernardino. It is anticipated that enrollment in Sonoma County will begin in 2012.~~

INFORMATION ONLY:

The expansion is expected to be cost neutral based on a cost analysis of ALW enrollees.

4. Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver Expansion

AB 359 (Chapter 845, Statutes of 1999) required the Department to establish a pilot program to provide continuous 24-hour nursing care to medically fragile infants, children and adults with developmental disabilities in home-like community settings. The Department obtained a 1915(b) freedom of choice waiver which CMS approved for the period of August 16, 2001 through September 30, 2009.

The Department converted this waiver into a 1915(c) HCBS waiver, effective October 1, 2009 through September 30, 2012. DD/CNC waiver participants must be Regional Center consumers, require 24-hour continuous skilled nursing care, and be free of clinically active communicable diseases. Nursing care services are currently available in seven regional center catchment areas. The Department will expand to two additional areas adding 12 slots beginning in FY 2012-13. The expansion is expected to be cost-neutral based on a cost analysis of DD/CNC waiver enrollees.

To create administrative efficiency, the Department has requested CMS approval of DD/CNC Waiver services as part of the Nursing Facility/Acute Hospital (NF/AH) waiver.

5. IHSS Provider Tax

AB 1612 (Chapter 725, Statutes of 2010) mandates that IHSS providers be taxed at the State sales tax rate. In exchange, the providers will receive a supplementary payment through CDSS equal to the amount of the tax, plus the federal income, Social Security and Medicare tax liabilities on that supplementary payment. The Department will provide the Title XIX federal funds for the supplementary payments for services provided to Medi-Cal beneficiaries ~~retroactive to October 1, 2010, and upon approval of a SPA that was submitted to CMS in December 2010.~~ **The SPA is pending CMS approval and the clock is stopped.**

FAMILY PACT**BREAST AND CERVICAL CANCER TREATMENT****PHARMACY****1. Average Acquisitions Cost as the New Drug Reimbursement Benchmark**

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source ceased publishing AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new methodology for Medi-Cal drug reimbursement that is based on average acquisition cost (AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

2. Federal Upper Limit

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The

INFORMATION ONLY:

Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs. On May 23, 2011, CMS reported that a notice of proposed rulemaking (NPRM) implementing the changes to AMP had been drafted and was under review. The Department plans to implement the FULs, after federal regulations have been published and/or final FULs are provided by CMS.

1115 WAIVER—MH/UCD & BTR**1. South LA Preservation Fund – Deferral**

The Department made payments from the South Los Angeles Medical Services Preservation Fund (SLAMSP) to LA County. The payments were consistent with the Special Terms and Conditions for the MH/UCD, which require SNCP funds be claimed based on the certified public expenditures of designated public hospitals, or the governmental entities with which they are affiliated, or based on certain designated State program expenditures.

CMS had raised questions and deferred \$255.2 million related to the costs incurred by LA County as contract payment for nonhospital services rendered to the uninsured by private providers. The deferral is due to the lack of a specific protocol in the Special Terms and Conditions for the Demonstration related to the use of the SNCP funding allotment for the SLAMSP.

The Department responded on May 2, 2011 discussing the rationale for concluding that claiming for the contract payments counties have with private providers is appropriate under the 1115 Waiver. In January 2012, CMS approved the contract payments with private providers issue. ~~The Department expects LA County to claim the remaining SLAMSP in FY 2011-12.~~ **The Department anticipates the deferral to be officially lifted upon CMS notification. In addition, CMS allowed the Department to make final payments of the remaining SLAMSP funds in FY 2011-12.**

MANAGED CARE**PROVIDER RATES****SUPPLEMENTAL PAYMENTS****1. Designated Public Hospitals – Seismic Safety Requirements**

AB 303 (Chapter 428, Statutes of 2009) authorizes Medi-Cal supplemental reimbursement to Designated Public Hospitals for debt service incurred for the financing of eligible capital construction projects to meet seismic safety requirements.

Eligible projects will be limited to meeting seismic safety deadlines, and will include those new capital projects funded by new debt for which final plans have been submitted to the Office of Statewide Health Planning and Development after January 1, 2007, and prior to December 31, 2011.

There will be no expenditures from the State General Fund for the nonfederal share of the supplemental reimbursement. The nonfederal share will be comprised of either certified public expenditures or intergovernmental transfers.

INFORMATION ONLY:

The Department is assessing federal approval requirements for implementation of this supplemental payment program. Implementation will occur only if federal approvals are obtained and federal financial participation is available.

2. Hospital Inpatient Rate Freeze

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

OTHER: AUDITS AND LAWSUITS**1. Mission Hospital Regional Medical Center and Kaiser Foundation Hospitals et al. v. Douglas**
(Reworded)

Plaintiffs are approximately 100 California hospitals that filed litigation in 2005 to challenge the validity of a limit on Medi-Cal reimbursement for FY 2004-05 for non-contract hospitals, which was enacted by SB 1103 (Chapter 228, Statutes of 2004). Plaintiffs contend the SB 1103 reimbursement limit violates the federally approved State Plan and various federal Medicaid laws, including 42 United States Code (U.S.C.) section 1396a(a)(30)(A), as well as the due process clause and contracts clause of both the United States and California constitutions.

The trial court issued an order June 19, 2009 that required the Department to recalculate the rates for the plaintiff hospitals for FY 2004-05 without applying the SB 1103 limit and pay them the additional money they would be owed. The Department appealed, and the Court of Appeal reversed the trial court's order. At a hearing on April 27, 2012, the trial court denied the plaintiffs' motion to amend their lawsuit to state a claim for money based on the state recalculating their rates for FY 2004-05 without applying the SB 1103 limit. A judgment is expected soon that will deny the plaintiffs the recalculated rates they seek. However, the plaintiffs filed a new lawsuit in November 2011 in which they again challenge the validity of the SB 1103 reimbursement limit and the new lawsuit specifically seeks a court order to require the Department to recalculate rates for FY 2004-05 without applying the SB 1103 reimbursement limit.

INFORMATION ONLY:**2. California Association for Health Services At Home, et al., v. Sandra Shewry (Reworded)**

Plaintiffs (an association of home health care providers, a home health care provider, and a disability rights advocacy group) filed a lawsuit on April 27, 2004 seeking reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement; the Medicaid Act's "access" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan.

In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that:

- The Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 U.S.C. 1396a(a)(30)(A), and
- The Department was not obligated to set new rates - i.e., for years after 2005.

Following the appellate decision, the Department completed a rate review and concluded that rates were consistent with section 1396a(a)(30)(A). After the rate review was filed with the trial court, plaintiffs objected. On September 25, 2009, the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v. Belshe*. The court ordered the Department to perform a further rate review.

The Department appealed the trial court's ruling. On March 26, 2012, the appellate court issued a published decision, affirming in part and reversing in part, holding:

- The Department was not required to consider provider costs under section 30(A) when performing the rate review,
- Section 30(A)'s requirement of "efficiency" and "economy" did not impose a minimum limit for Medi-Cal reimbursement rates,
- Lack of complaints was sufficient to establish quality of care under section 30(A), and
- Sufficient evidence supported the Department's finding of access to care under section 30(A).

The Department is currently completing a supplemental rate review consistent with the appellate court decision.

3. California Hospital Association v. Shewry (Reworded)

The California Hospital Association (Plaintiff) is a trade association representing nursing facilities that are a distinct part of a hospital (DP/NFs). Plaintiff contends the Department's policy of excluding the projected costs of facilities with less than 20% Medi-Cal days in determining the median rate results in rates that violate various laws, including 42 U.S.C. section 1396a(a)(30)(A). Plaintiff also contends that the freeze in rates during rate year 2004-05 violated section 1396a(a)(30)(A). Plaintiff seeks an injunction against the continued use of the 20% exclusion policy and a writ of mandate requiring the Department to recalculate rates for rate years 2001-02 through 2005-06 and pay DP/NFs the additional amount owed based on the recalculations.

On August 20, 2010, the Court of Appeal issued a decision reversing the trial court's judgment in favor of the Department. The Court of Appeal held that the Department violated section 1396a(a)(30)(A) by failing to evaluate whether rates were reasonable relative to provider costs. The case has been remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 through 2005-06. So far, there has been some additional discovery, but no other activity has occurred since the remand.

INFORMATION ONLY:4. *Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services* (Reworded)

Plaintiffs are 17 hospitals that contend that the 10% Medi-Cal payment reductions the Department implemented, pursuant to ABX4 5 (Chapter 5, Statutes of 2009), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30), the Supremacy Clause and Equal Protection Clause of the United States Constitution, the State Plan, and state law. Plaintiffs seek declaratory relief and a permanent injunction against the payment reductions. The status of the case is as follows:

- On February 20, 2009, the federal court denied plaintiffs' motion for preliminary injunction,
- On June 1, 2009, the Ninth Circuit dismissed the plaintiffs' appeal. Plaintiffs filed an amended motion for preliminary injunction with respect to the 10% payment reductions mandated by W&I Code section 14166.245,
- On November 18, 2009, the district court issued a preliminary injunction with respect to the 90% of allowable cost standard mandated by Section 14166.245. The Department appealed,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy Clause to sue states over whether provider rates comply with 42 U.S.C. section 1396a(a)(30)(A), and
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction.

5. *Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly* (Reworded)

This lawsuit challenges the 10% reduction required by ABX4 5 (Chapter 5, Statutes of 2009) in Medi-Cal payments that took effect on July 1, 2008. These reductions are mandated by W&I Code sections 14105.19 and 14166.245. Plaintiffs contend that these reductions violate 42 U.S.C. section 1396a(a)(30)(A) and the Americans with Disabilities Act. The status of this case is as follows:

- On August 18, 2008, the district court issued a preliminary injunction against the 10% reduction for physicians, dentists, optometrists, adult day health care centers, clinics, and for prescription drugs for services on or after August 18, 2008,
- On November 17, 2008, the district court issued a preliminary injunction against the 10% reduction for home health and non-emergency medical transportation (NEMT) services for services on or after November 17, 2008,
- On July 9, 2009, the Ninth Circuit issued a decision affirming the district court's August 18, 2008, preliminary injunction. The Ninth Circuit further granted plaintiffs' appeal with respect to their claim that the district court's August 18, 2008, injunction should have applied to service back to July 1, 2008,
- On August 7, 2009, the Ninth Circuit issued a decision affirming the district court's preliminary injunction with respect to NEMT and home health services,
- On January 22, 2010, the district court issued an order requiring the Department to pay additional money due for July 1, 2008 through August 17, 2008 to providers in the 6 categories covered by the August 18, 2008 injunction,
- On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy clause to sue states over whether provider rates comply with 42 U.S.C. section 1396(a)(30)(A), and

INFORMATION ONLY:

- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case to the Ninth Circuit to reconsider the Department's appeals of the two injunctions. This will require a new appellate court briefing, which has been postponed to allow the parties to first explore possible settlement of the litigation.

6. Yoo, Chang Ho dba PCH Medical Pharmacy, et al v. Sandra Shewry (Reworded)

The Department temporarily withheld reimbursement payments to Medi-Cal providers where it had reliable evidence of fraud or abuse of the Medi-Cal Program. Petitioners allege that the Department has violated State and federal law because the Department did not pay interest on amounts subject to temporary withhold.

On November 26, 2008, the trial court found that implied authority exists to require the Department to pay interest if funds are temporarily withheld more than 150 days. This ruling would have impacted the Department's implementation of temporary withholds to protect the Medi-Cal Program against fraud and abuse. The Department appealed the decision and the appellate court reversed it, holding that the law does not require payment of interest based on the temporary withholding of payments. The plaintiff then filed an amended complaint. Over the Department's objection, on July 8, 2011, the trial court certified this legal issue for immediate appellate review. On September 15, 2011, the appellate court directed the Superior Court to enter judgment in favor of the Department and upholding the ruling that the law does not require payment of interest. The case was closed in December 2011.

7. AB 1183 Litigation (Reworded)

Two lawsuits challenged provider payment reductions that were mandated by AB 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs, adult day health care center (ADHC) services, and other hospital services.

- In the *Independent Living Center of Southern California* (formerly *Managed Care Pharmacy*) v. *Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs. The Department appealed and the Ninth Circuit affirmed the preliminary injunction. On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy clause to sue states over whether provider rates comply with 42 U.S.C. section 1396a(a)(30)(A).
- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHC services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Ninth Circuit issued two decisions that affirmed preliminary injunctions against the AB 1183 payment reductions for ADHC and hospital services. On February 22, 2012, the Supreme Court issued a ruling that vacated the Ninth Circuit decisions and remanded both cases back to the Ninth Circuit to reconsider the Department's appeals of the three injunctions in the above cases. This will require a new appellate court briefing, which has been postponed to allow the parties to first explore possible settlement of the litigation.

INFORMATION ONLY:**8. AB 97 Litigation**

Four lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

- *California Hospital Association v. Douglas, et al.*

Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011 shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government (Secretary of the Department of Health and Human Services, Kathleen Sebelius), which recently approved a State Plan Amendment (SPA) concerning these reductions, has been named as a co-defendant.

On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. The Department appealed. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011 that were not reimbursed prior to that date. Plaintiffs appealed that ruling. On March 22, 2012, the Ninth Circuit denied the Department's request for stay of the injunction pending its appeal. The parties have completed their appellate briefs and the hearing is set for October 10, 2012.

- *Managed Pharmacy Care, et al. v. Sebelius, et al.*

Plaintiffs, a Medi-Cal beneficiary, five pharmacies, a statewide pharmacy member group, an independent living center, and the state association of independent living centers, challenge the October 27, 2011 action of defendant Secretary of the U.S. Department of Health and Human Services (HHS), approving a SPA of defendant California Department of Health Care Services for a 10% Medi-Cal payment reduction. Plaintiffs allege that Medi-Cal payment reductions mandated by AB 97 (as amended by AB 102) violate requirements set forth in 42 U.S.C. section 1396a(a)(30)(A), and that HHS violated the Federal Administrative Procedure Act in approving the SPA. Plaintiffs also allege violation of the due process clause of the 14th Amendment, the Fifth Amendment, and the Privileges and Immunities Clause of the U.S. Constitution.

On December 28, 2011, the district court issued an injunction enjoining implementation of the reduction on Medi-Cal reimbursement to providers of pharmacy services in the Medi-Cal fee-for-service program on or after June 1, 2011. All requests for stay have been denied. On March 12, 2012, the district court issued an order modifying the preliminary injunction to allow the Department to apply the payment reduction to services rendered from June 1, 2011 through December 27, 2011 that are reimbursed for the first time on or after December 28, 2011. The parties have completed their appellate briefs and the hearing is set for October 10, 2012.

- *California Medical Transportation Association v. Douglas, et al.*

Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

INFORMATION ONLY:

On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. Defendants appealed. Plaintiffs appealed the court's decision allowing some retroactive implementation of the reduction. The parties have completed their appellate briefs and the hearing is set for October 10, 2012.

- California Medical Association v. Douglas, et al.

Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government (Kathleen Sebelius, Secretary of Health and Human Services), which recently approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012 that are not reimbursed at the unreduced rates prior to that date. The Department appealed, and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. The parties have completed their appellate briefs and the hearing is set for October 10, 2012.

9. California Hospital Association v. David Maxwell-Jolly (Reworded)

This lawsuit seeks to enjoin a "freeze" in rates for the 2009-10 rate year (i.e. freeze rates at the 2008-09 rate levels) for hospital based nursing facility and sub-acute care services and the extension to some small and rural hospitals of the 10% reduction for non-contract hospital inpatient services. Plaintiff alleges violations of various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30), and that implementation of these statutory changes is preempted by the Supremacy clause of the United States Constitution.

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department's motion for a stay of appellate proceedings pending petitions for certiorari in Maxwell-Jolly v. Independent Living Centers and Maxwell-Jolly v. California Pharmacists Association. On March 30, 2012, the Ninth Circuit ordered an end to the stay. This case has been referred to non-binding mediation in the Ninth Circuit, so there will be no further briefs submitted by the parties until the mediation is complete.

10. California Association of Rural Health Clinics, et al. v. Maxwell-Jolly (Reworded)

Plaintiffs, an individual Federally Qualified Health Center (FQHC) and an association representing multiple Rural Health Clinics (RHCs), allege that the Department illegally applied the 2009 elimination of certain optional Medi-Cal benefits required by ABX3 5 (Chapter 20, Statutes of 2009) to FQHCs and RHCs. Plaintiffs contend that certain benefits are mandatory when provided by an FQHC and seek to compel the Department to continue to reimburse FQHCs for these services. Plaintiffs contend that W&I Code section

INFORMATION ONLY:

14131.10 is preempted via the Supremacy Clause of the US Constitution as to Departmental payment to FQHCs and RHCs for the provision of these eliminated benefits.

On October 20, 2010, the district court issued an order enjoining the Department from disallowing certain optional benefits to RHCs and FQHCs until the applicable SPA was approved by CMS. Both the Department and Plaintiffs appealed. The SPA was approved by CMS on May 23, 2011. Plaintiffs are still challenging the elimination of optional benefits based on “new evidence” they allege they have discovered. The Department is requesting that this issue be sent back to the district court for consideration. In the meantime, the issue of whether the Department can implement a reduction of services prior to CMS’ approval of a SPA remains in front of the Ninth Circuit Court of Appeals.

11. Managed Care Potential Legal Damages (Reworded)

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate setting methodology for the rate years from 2002 through 2005. The cases are referred to as:

- *Santa Clara Family Health Authority dba Santa Clara Family Health v. DHCS*
- *Health Net of California, Inc. v. DHCS*
- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

On April 20, 2011, the trial court issued a judgment in favor of the plaintiff in the Santa Clara County Health Authority case and on June 13, 2011, judgment was issued in favor of the plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. The Department is in appellate mediation on damages and interest for each of these cases, but mediation has not been completed.

Molina Healthcare of California v. Toby Douglas

Antelope Valley Hospital sued Molina Healthcare for failure to pay the interim rate for emergency services (rather than the average CMAC rate). Molina then cross-complained against Health Net and the Department seeking compensation from both in Superior Court. Health Net has now filed an administrative appeal seeking indemnification from the Department. The parties are currently engaged in settlement negotiations.

AIDS Healthcare dba Positive Healthcare

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As the result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff filed an appeal, and argument was held on October 12, 2011. On November 3, 2011, the Ninth Circuit U.S. Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court’s dismissal of the case. Plaintiff’s claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA will proceed. The Court ordered a pre-trial conference on September 24, 2012 and trial on October 23, 2012.

INFORMATION ONLY:12. MCHA v. DHCS and MRMIB

This assumption has been moved to “Eligibility: New Assumptions” section.

13. Darling et al. v. Toby Douglas (Reworded)

This lawsuit sought to enjoin the elimination of Medi-Cal coverage of adult day health care (ADHC) services, as required by AB 97 (Chapter 3, Statutes of 2011). Plaintiffs contend that elimination of Medi-Cal covered ADHC services violates various federal laws, including the Americans with Disabilities Act. The Department and plaintiffs entered into a settlement agreement, which was approved by the court in January 2012. The settlement ended ADHC services effective February 29, 2012, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective March 1, 2012. The settlement agreement will be in effect until August 2014, with the court retaining jurisdiction during the pendency of the settlement.

14. California Association of Health Facilities, et al. v. Toby Douglas (Reworded)

This lawsuit seeks to enjoin a freeze in the Medi-Cal rates paid to intermediate care facilities for the developmentally disabled (ICF/DDs), including ICF/DD-Hs (habilitative) and ICF/DD-Ns (Nursing), and freestanding pediatric sub-acute care facilities (W&I Code section 14105.191 (f)(2)). Plaintiffs contend that the state violated 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30)(A) in enacting and implementing the rate freeze, and that the freeze statute is therefore preempted by federal law under the supremacy clause of the United States Constitution. The status of the case is as follows:

- On May 6, 2011, the court issued a preliminary injunction against the rate freeze,
- On June 28, 2011, the United States Court of Appeals (Ninth Circuit) granted the Department request for a stay of the preliminary injunction pending appeal,
- On November 30, 2011, the Ninth Circuit issued a decision reversing the preliminary injunction, and
- On March 21, 2012, the district court granted plaintiffs’ motion for leave to amend their complaint to state a claim under the “takings” clause of the Constitution, and to name HHS Secretary Sebelius as a defendant. The district court stayed further litigation pending a decision by the Ninth Circuit on remand in the Independent Living litigation.

15. California Pharmacists Association v. David Maxwell-Jolly (Reworded)

This lawsuit challenges the legality of a new upper billing limit provision concerning maximum allowable ingredient costs (MAICs) and the use of recently reduced average wholesale prices (AWPs) in reimbursing drugs. Plaintiffs claim that the State has not complied with 42 U.S.C. section 1396a(a)(30)(A) in enacting and implementing these changes.

On May 5, 2010, the district court issued an order granting preliminary injunction concerning the new upper billing limit and new MAICs, but denying preliminary injunction concerning the AWP reductions. The Department and plaintiff both appealed. On April 2, 2012, the Ninth Circuit lifted a stay of the appellate litigation that had been in effect. The preliminary injunction remains in effect. The Ninth Circuit has postponed appellate court briefing to allow the parties time to first explore possible settlement.

INFORMATION ONLY:**16. Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly**

This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The third cause of action (duty to review rates annually) was transferred to a different judge to be heard separately from the other two causes of action. Based on the hearing on the third cause of action, the Court ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. The Rate Review was filed with the court on December 16, 2011. On March 15, 2012, the court ordered the parties to proceed on the two remaining causes of action. On April 30, 2012, the Department filed a demurrer to the (a)(30)(A) cause of action. The hearing on the demurrer was held on June 28, 2012, and the demurrer was sustained without leave to amend, which disposed of the second cause of action. The Department intends to file a motion for summary judgment on the remaining Equal Protection cause of action.

OTHER: REIMBURSEMENTS**1. Federal Upper Payment Limit**

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

The UPL only applies to private hospitals and non-designated public hospitals that are part of the category of "non-state government-owned hospitals". The UPL for designated public hospitals consists of audited costs.

2. Selective Provider Contracting Program Waiver Renewal

The 1915(b) waiver that authorized the SPCP allowed California to negotiate contracts with hospitals for inpatient services on a competitive basis expired on August 31, 2005. However, the Department was allowed to continue the SPCP under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver which ended on October 31, 2010. The BTR Waiver was approved November 1, 2010 for five years and includes continuation of the SPCP.

On July 1, 2013, the Department will implement a new payment system, which will replace the SPCP and existing non-contract payment system, currently utilized with a system based on diagnosis related groups (DRG). The DRG payment system will pay for inpatient fee for service hospital stays at all hospital except for Designated Public Hospitals. Rehabilitation and psychiatric stays will not be reimbursed by the DRG payment system. The implementation of the DRG payment system is expected to generate ongoing general fund savings compared to what would have occurred under the existing methodology due to the ability of the Department to eliminate the annual increases that currently occur under the contract rate and non-contract cost methodologies.

INFORMATION ONLY:**3. Accrual Costs Under Generally Accepted Accounting Principles**

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (~~FY 2010-11~~) (**FY 2011-12**), the June 30, 2011 **2012** Medi-Cal accrual amounts were estimated to be ~~\$1.33~~ **\$1.95** billion state General Fund and ~~\$5.43~~ **\$7.42** billion federal funds, for a total of ~~\$6.76~~ **\$9.37** billion.

4. Freestanding Clinic – Former Agnews State Hospital

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

5. Refund of Recovery

CMS requested the Department prepare reconciliations of Grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of \$240 million FFP for federal FY 2007 through 2011 and \$34 million FFP ongoing each month.

OTHER: RECOVERIES**FISCAL INTERMEDIARY: MEDICAL****1. CA-MMIS Replacement – TPL and ACMS**

This assumption has been moved to the "CA-MMIS Replacement – Claims and All Other Remaining Operations" assumption.

INFORMATION ONLY:2. CA-MMIS Replacement – Claims and All Other Remaining Operations

The Department will replace core CA-MMIS functionality, including hardware and software components, during the final phase of the CA-MMIS Replacement Design, Development and Implementation (DD&I). This replacement component is planned for implementation within 54 months of AOO. Payments for these costs are expected to be made after FY ~~2012-13~~ **2013-14**. **The Department and its FI have agreed to include CA-MMIS Third Party Liability (TPL) and Automated Collection Management System (ACMS) replacement into the final replacement phase.**

3. Provider Enrollment Automation Project

~~Beginning in FY 2012-13, the~~ **The** Department will ~~implement~~ evaluate an Optional Contractual Service (OCS) under the FI contractor to enhance the current CA-MMIS Health Enterprise Provider Enrollment functionality. This will provide Medi-Cal providers with web-based, high-speed access to fully automated e-forms; imaging; communications; and workflow management, as well as reporting features to support timely, accurate, and efficient receipt and processing of provider enrollment and re-enrollment applications.

This OCS is under the Department's evaluation.

4. FI Assumption of Operations Delay Reimbursement

In May 2010, the Department awarded the medical fiscal intermediary contract to ~~Affiliated Computer Services (ACS)~~ **Xerox** to assume the responsibilities for Medi-Cal claims processing functions as well as to replace the current CA-MMIS. The AOO by ~~ACS~~ **Xerox** was scheduled for February 1, 2011, but delayed to June 13, 2011. ~~ACS~~ **Xerox** has agreed to reimburse the Department for costs related to this delay.

In January 2011, ~~ACS~~ **Xerox** delayed the AOO from June 13, 2011 to September 30, 2011. The Department and ~~ACS~~ **Xerox** are in the process of determining ~~ACS' liability due~~ **costs related** to the second AOO delay.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**FISCAL INTERMEDIARY: DENTAL**1. Medi-Cal Dental FI Contract – Optional Contractual Services

The CD-MMIS is the Medi-Cal dental claims processing system operated by the dental FI. ~~It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published in August 2011. The Medi-Cal Dental RFP allows proposers to submit up to three Optional Contractual Services (OCS) that relate to claims processing or other services required by the RFP. The Department has the option to purchase any OCS submitted by any proposer;~~ **however, the Department is exercising the one-time extended operations option of the current Dental FI Contract for a period of 12 months, therefore, the option to purchase any OCS will be delayed.**

2. CMS' Determination That Dental Contract is Not Valid MMIS

This assumption has been moved to "Fiscal Intermediary: Dental: New Assumption" section.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

ELIGIBILITY

1. Low-Income Subsidy Applications Treated as Medi-Cal Applications

Beginning January 1, 2010, the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 requires all states to process SSA Low-Income Subsidy (LIS) applications (Part D) as an application for the Medicare Savings Program (MSP). Counties have also been instructed to use the LIS application as an application for Medi-Cal. The date the SSA receives a LIS application will also be considered the date of the state Medi-Cal application, thus starting the 45-day clock for determining Medi-Cal eligibility. Since the LIS applications do not contain enough information to determine Medi-Cal eligibility, the counties will have to establish files in MEDS and request additional information from all LIS applicants on the SSA lists. This federal requirement will result in an increase in caseload duties for county eligibility workers and additional benefit costs.

BENEFITS

1. Limit Enteral Nutrition to Tube Feeding

Effective October 1, 2011, AB 97 (Chapter 3, Statutes of 2011) limited enteral nutrition products to those products to be administered through a feeding tube. The Department deems enteral nutrition products not administered through a feeding tube a benefit for patients with diagnoses including, but not limited to, malabsorption syndromes or inborn errors of metabolism. Children eligible for EPSDT are exempt from this limitation.

2. Elimination of OTC Acetaminophen Drugs

SB 853 (Chapter 717, Statutes of 2010) eliminated specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.

3. Eliminate ADHC Services

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program.

HOME & COMMUNITY-BASED SERVICES

FAMILY PACT

BREAST AND CERVICAL CANCER

PHARMACY

1. EPC for Average Wholesale Price Frozen Rates

First Databank, the Department's primary drug price reference source, ceased publishing average wholesale prices (AWP) in September 2011. Drug claims for Medi-Cal FFS pharmacy providers submitted for reimbursement for dates of service after September 22, 2011 may be subject to erroneous payment correction (EPC). The EPC claim cycles, for all pharmacy drug claims with dates of service between September 2011 and March 2012 have commenced.

DISCONTINUED ASSUMPTIONS**Fully Incorporated Into Base Data/Ongoing****1115 WAIVER—MH/UCD & BTR****MANAGED CARE****1. Coverage for Former Agnews Residents**

The CDDS submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. Agnews closed in March 2009 and all consumers have been transitioned to the community. The Department has developed agreements with three health plans, regional centers and CDDS to address the medical health needs of consumers transitioning from Agnews into Alameda, San Mateo, and Santa Clara counties pursuant to the Agnews Closure Plan, whose Individual Program Plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system and who choose to enroll in a managed care plan. The Department established a mechanism whereby the plans were paid a supplemental payment in addition to the capitation rate for these individuals, followed by periodic reconciliations to reimburse the plans for reasonable costs. In December 2010, the Department implemented new full risk rates retroactively to July 1, 2008 for the Health Plan of San Mateo and January 1, 2008 for Santa Clara, Family Health Plan. The Alameda Alliance for Health contract was amended in September 2011 with new full risk rates retroactive to January 1, 2008.

2. Mandatory SPD Enrollment into Managed Care

Effective June 1, 2011, it is mandatory for all Medi-Cal Seniors and Persons with Disabilities (SPDs) residing in managed care counties, and not dually eligible for Medicare, to enroll in a managed care plan. Previously, only SPDs in County Organized Health System counties were required to enroll in managed care.

PROVIDER RATES**SUPPLEMENTAL PAYMENTS****1. Non-Contract Hospital Rate and Payment Changes**

SB 90 repealed a number of rate and payment reductions for non-contract hospital inpatient services. These include:

- ABX3 5 (Chapter 3, Statutes of 2008) 10% reduction of non-contract hospital inpatient payments;
- AB 1183 (Chapter 758, Statutes of 2008), the Budget Trailer Bill required additional rate reductions for the inpatient services of certain non-contract hospitals; and exempted the inpatient services of non-contract Small and Rural Hospitals from the 10% payment reduction; and
- ABX4 5 (Chapter 5, Statutes of 2009) 10% payment reduction of certain non-contract Small and Rural Hospital inpatient services.

OTHER: AUDITS AND LAWSUITS

DISCONTINUED ASSUMPTIONS**Fully Incorporated Into Base Data/Ongoing****OTHER: REIMBURSEMENTS****1. Discontinue Part B Premium for Unmet Share of Cost Beneficiaries**

The Budget Act of 2010 included the elimination of payment of the Medicare Part B premiums for beneficiaries with an unmet share of cost (SOC) of \$500 or less. Payment of the premiums for those with unmet SOC's greater than \$500 was eliminated effective December 1, 2008.

OTHER: RECOVERIES**1. Anti-Fraud Initiative**

Effective July 1, 2010, the Department expanded its anti-fraud activities for physician services using preventative, front-end claims analyses tools.

FISCAL INTERMEDIARY: MEDICAL**2. HIPAA – Provider Relations**

Provider relations are an essential component of the activities relating to HIPAA. Additional Fiscal Intermediary (FI) staffing will be necessary to obtain appropriate provider feedback on proposed HIPAA changes and to provide technical assistance specific to the many CA-MMIS and claims processing changes resulting from these projects. Clear and accurate communication is vital and will be supplemented by provider bulletins, seminars, interactive workshops, and other notices via mail and the Internet. This activity is in addition to the provider relation activities already funded in the FI fixed price contract. The costs for the additional activity were authorized through the change order process.

FI staff will be utilized to accommodate increased suspense rates and provider appeals with each code conversion, claim transaction and unique identifier implementation while providers become accustomed to the changes.

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was in September 2003. The remaining transactions and code conversions will continue to be phased-in. The FI continues working on implementing the National Provider Identifier. Under the ACS Contract, HIPAA Provider relations are covered under the fixed price beginning October 3, 2011

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**1. Additional Contractual Service – Initial Health Screen Questionnaire**

The HCO contract includes an Additional Contractual Service. The Department implemented the Initial Health Screen Questionnaire Additional Contractual Service in March 2011. This questionnaire helps ensure that applicants and beneficiaries with existing disabilities or chronic conditions identify themselves so as to receive immediate access to care. The questionnaire is currently being mailed within the HCO informing packet. This Additional Contractual Service is consistent with the Department's continued commitment to serve this population.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

ELIGIBILITY

1. Health-e App

Health-e App is an electronic, web-based Healthy Families application used to screen for Medi-Cal children's percent programs. It is intended to reduce the application processing time so that children can obtain needed Healthy Families or Medi-Cal coverage as quickly as possible and is available to enrollment entities in all California counties. The California Health Care Foundation (CHCF) that owns the system has made system changes to enable the general public to use Health-e App.

The Department pays for the federal Title XIX share of this cost through an interagency agreement with MRMIB. MRMIB budgets the federal Title XXI share of the cost. The CHCF grants the matching funds for the federal Title XIX and Title XXI funding.

The implementation of Health-e App public access statewide was December 2010. In FY 2011-12 costs include the design of an outreach campaign which will promote the statewide launch of Health-e App public access.

2. Craig v. Bontá Disallowance

As a result of *Craig v. Bontá* counties were instructed that Medi-Cal beneficiaries losing SSI/SSP based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal eligibility automatically discontinued. These cases must first be reviewed and evaluated for eligibility in other Medi-Cal programs using the three-step SB 87 redetermination process.

CMS has determined there is a disallowance of federal funding for failure to make prompt Medicaid eligibility determinations after beneficiaries were found to be ineligible for SSI based Medi-Cal. The Department will provide repayment of FFP to CMS for the period of April 2003 through September 2004.

BENEFITS

1. Disease Management Program

W & I Code Section 14132.27 requires the Department to test the efficacy of providing a disease management (DM) pilot benefit to fee-for-service Medi-Cal beneficiaries. In response to CMS and industry input, the Department has elected to implement the pilot program to test the disease management benefit through an administrative model that does not require CMS approval. The effectiveness of this benefit included demonstration of the cost neutrality of the DM program. The Department entered into contracts to cover various conditions within the pilot program. UCLA has been contracted to conduct an independent evaluation of the DM program administered through a contract with McKesson Health Solutions.

HOME & COMMUNITY-BASED SERVICES

FAMILY PACT

BREAST AND CERVICAL CANCER

PHARMACY

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

1115 WAIVER—MH/UCD & BTR

1. MH/UCD –South LA Preservation Fund

SB 474 (Chapter 518, Statutes of 2007) created the South Los Angeles Medical Services Preservation (SLAMSP) Fund to ensure adequate funding for the continued health care services to the uninsured population of South Los Angeles, which had been provided by Martin Luther King Jr.-Harbor Hospital. In 2007, Martin Luther King Jr.-Harbor hospital, a DPH receiving SNCP funds, was closed. Through the SLAMSP Fund, the County of Los Angeles will be able to receive federal funds using the county's CPEs related to compensating other providers for health services rendered to the uninsured population of South Los Angeles that would have been served at Martin Luther King Jr.-Harbor Hospital. The County of Los Angeles can also use this funding to cover indirect costs associated with adequately maintaining the hospital building for reopening. Up to \$100 million in SNCP federal funds for the last three years of the Demonstration Project are to be allocated to the SLAMSP fund. This funding ends October 31, 2010, with the expiration of the Demonstration Project. Under the BTR, no separate funding is allocated to SLAMSP.

MANAGED CARE

1. Court-Ordered Managed Care Rate Adjustments

In the case of *HealthNet of California v. Department of Health Services*, due to a ruling by the Third District Court of Appeal, the Department paid \$17.59 million, including post-judgment interest, to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. In FY 2009-10, \$14.6 million was paid to Health Net and the remaining \$2.99 million was paid to the health plan in December 2010. The Department paid the prejudgment interest in February 2012, which is \$32.4 million.

2. Rate Increases due to SB 90 IGTs

SB 90 (Chapter 19, Statutes of 2011) requires the Department to design and implement an intergovernmental transfer program. This program is for Medi-Cal managed care services provided by designated and non-designated public hospitals. The program increases capitation payments and raises the hospitals' reimbursement. Participation in the intergovernmental transfers is voluntary on the part of the transferring entities. These transfers are for the nonfederal share of the capitation rate increases.

The program is applicable for the period of January 1, 2011 through June 30, 2011. The Department received CMS approval on December 30, 2011.

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

1. MH/UCD & BTR—Private Hospital DSH Replacement

SB 90 reduced Medi-Cal DSH replacement payments to private hospitals by \$30 million GF in FY 2010-11 and \$75 million GF in FY 2011-12.

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

OTHER: AUDITS AND LAWSUITS

1. Minor Consent Settlement

On June 17, 2002, the Department, Los Angeles County, and the U. S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from 1993 to 1999. The terms of the settlement include payment of \$73.3 million, plus interest, of which Los Angeles County paid \$6.8 million within 10 days of receipt of the fully executed agreement. The balance of \$66,500,000, plus interest, will be withheld from California's Medicaid payments over ten years, with the first "adjustment" to be made July 1, 2003.

OTHER: REIMBURSEMENTS

1. Federal Flexibility and Stabilization - Additional Federal Reimbursement

The Department received enhanced ARRA FMAP ratio for the Medicare Part D Phased-down Contribution payments, lowering state payments to the federal government. The Department requested, but did not receive, federal reimbursement for health care costs for disabled individuals who were eligible for Medicare and the recalculation of the Medicare Part D Phased-down Contribution base.

2. Drug Medi-Cal – CDADP

The Drug/Medi-Cal program provides substance abuse treatment services to Medi-Cal beneficiaries in an outpatient setting.

Drug/Medi-Cal services are reimbursed on a fee-for-service (FFS) basis. These community treatment services are carved out from the regular Medi-Cal program and are administered by the CDADP.

Title XIX FFP is claimed for Drug Medi-Cal services administered by the CDADP.

Effective July 1, 2012, the CDADP administrative staff and associated federal funding will be shifted to the Department's state operations.

3. Reduction in IMD Ancillary Services Costs

The W&I code requires that any state and federal Medi-Cal funds paid for the cost of ancillary services for Medi-Cal eligibles, 21 years of age and older or who have not attained 65 years of age and who are residents of Institutions for Mental Diseases (IMDs), be recovered from counties by the California Department of Mental Health (CDMH). The Department is developing processes in collaboration with CDMH to stop and to collect deny inappropriate billing for ancillary services.

4. Emily Q. – Special Master

The Department is engaged in implementation of the *Emily Q.* litigation. *Emily Q.* is a class action case for children in foster care that was filed in Federal Court in Los Angeles in 1999. The case was settled in 2002 and the parties have been working towards finalizing implementation pursuant to the stipulated judgment. The Department was ordered to provide individualized comprehensive home

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

and community-based mental health benefits and services to Medicaid-eligible children as required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The court ordered the parties to collaborate on a plan for increasing “therapeutic behavior services” (TBS) utilization, and appointed a special master to assist the parties in resolving the outstanding issues.

5. ARRA – Additional FFP for DHCS

On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010 which provides an across-the-board increase to all states of 6.2 percent and an additional increase in the form of a decrease in the state share based on increased unemployment rates. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period. Among other conditions, ARRA requires that eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Section 1115 waiver program cannot be more restrictive than those in effect as of July 1, 2008. Compliance with provider prompt payment requirements, including hospitals and nursing homes, is also a condition of receiving the enhanced FMAP.

6. Refunds on Acts of Fraud

CMS provided clarification on the FFP of Medicaid recoveries pursuant to legal action under the False Claims Act (FCA). Under the FCA, settlements are shared among the states, the federal government and the whistle-blower. The Department estimates a \$97 million recoupment from the federal government due to:

- Incentive FFP for states that have enacted federally-compliant False Claims Act, and
- Settlement payments erroneously made to the federal government from the Department.

In addition, the Department expects \$45.9 million federal fund reimbursement in FCA relator costs.

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

1. Medi-Cal Fiscal Intermediary Contract Turnover

The Turnover period is to ensure an orderly transfer of the Medi-Cal Fiscal Intermediary contract from the current contractor to the successor contractor at the end of the contract. The Department extended the term of the current contract up to June 30, 2012 to continue uninterrupted support of ongoing operations. Turnover activities began January 1, 2008 and will end March 2012.

2. Additional Resources to Support CSU Operations

Additional funding is required to support operations of the Correspondence Specialist Unit (CSU) due to the implementation of SDN 09041 Optional Benefits Exclusions (OBE) Phase Three. A post payment audit of OBE claims generated by the implementation of SDN 09041 will be performed on a sample basis.

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

3. Additional Costs Associated with Delay in AOO

Due to the delay in AOO by ACS, there will be additional anticipated costs associated with HP for the following:

- Incremental turnover support beyond the contract required 12 months,
- Increases in short term lease payment for buildings,
- Increases in short term hardware and software maintenance agreements, and
- Potential increases in leases to replace failing equipment.

Payments are expected to be completed in FY 2011-12.

4. Termination of Convenience

Fiscal Intermediary (FI) HP Enterprise Services (HP) Contract 02-25999 was amended via Amendment 09 to provide an extension of the termination date from 30 to 90 days to retain HP as the FI due to ACS' delay in the Assumptions of Operations (AOO). Since ACS could not assure the Department of an AOO completion date until August 31, 2011, the Department could only provide HP with a 30-day notification rather than the 90-day notification requested by HP and contained in Amendment 09. As a result, the Department has agreed to reimburse HP for all reasonable and supported expenses related to this late notification.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. SPD Mandatory Enrollment into Managed Care HCO Costs

Effective June 1, 2011, it is mandatory for all Medi-Cal Only Seniors and Persons with Disabilities (SPDs) residing in managed care counties to enroll in a managed care plan. As a result, MAXIMUS, the HCO enrollment broker, is sending informing materials to each SPD beneficiary upon transitioning to a mandatory status for enrollment.

To meet the Department's outreach and education goals, MAXIMUS hired additional staff to aid the beneficiaries in this transition and to handle ongoing outreach and education.

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

BENEFITS

HOME & COMMUNITY-BASED SERVICES

1. Trigger Cuts to CDSS for IHSS

The Department of Social Services (CDSS) will budget a 7% across the board reduction to the In-Home Supportive Services (IHSS) program service hours.

CDSS will also eliminate domestic and related services for IHSS program recipients living in shared living arrangements, excluding those IHSS recipients who reside only with other IHSS participants.

The Department provides the FFP match for IHSS costs.

2. Administrative Costs for CCT

In January 2010, CMS announced the availability of 100 percent FFP for certain administrative costs under the Money Follows the Person (MFP) Rebalancing Demonstration Grant. The Department requested and was approved for 100 percent federal funding for 34 Regional Center positions that will focus on transitioning beneficiaries from the Lanterman Developmental Center to the community via the California Community Transitions (CCT), the MFP Grant.

FAMILY PACT

BREAST AND CERVICAL CANCER

PHARMACY

1. Pharmacy Copayment

AB 97 (Chapter 3, Statutes of 2011) requires mandatory copayments of \$3 for preferred drugs and \$5 for non-preferred drugs. This copayment will be implemented without exemptions in the managed care setting. The pharmacy will collect the copayment from the beneficiaries at the time of service and be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment. The Department is proposing legislation to revise the copayments from \$3 for preferred drugs or \$5 for non-preferred drugs to only a \$3.10 copayment for non-preferred drugs.

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

DISCONTINUED ASSUMPTIONS

Withdrawn

OTHER: REIMBURSEMENTS

1. Department of State Hospitals Admin. Costs

The Medi-Cal budget includes the estimated cost of federal funds for Health Insurance and Portability and Accountability Act (HIPAA) for California Department of State Hospitals.

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

1. Family PACT Retroactive Eligibility Claim Process

Effective April 1, 2011, the Department implemented a manual retroactive eligibility process for newly-enrolled qualified Family PACT clients. The manual process includes procedures to allow qualifying Family PACT clients to be reimbursed for qualifying out of pocket expenses for the prior three months before eligibility determination, and requires the FI to update all affected systems necessary to ensure proper payment of these Family PACT claims. This function continues under the new FI contract with ACS as of the AOO on October 3, 2011.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL